No. 05394

IN THE

Supreme Court of the United States

ELVIS KOBS,

Petitioner,

v.

UNITED WISCONSIN INSURANCE COMPANY,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR A WRIT OF CERTIORARI

LAURA W. BRILL
Counsel of Record
TED M. SICHELMAN
IRELL & MANELLA, LLP
1800 Avenue of the Stars
Los Angeles, California 90067
(310) 277-1010

JASON W. WHITLEY
NOVITZKE, GUST, SEMPF & WHITLEY
314 Keller Avenue North,
Suite 399
Amery, Wisconsin 54001
(715) 268-6130

Counsel for Petitioner Elvis Kobs

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QUESTIONS PRESENTED

(1) Whether an insurance company that both funds and makes discretionary benefits determinations under a plan governed by the Employment Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq., inherently acts under a conflict of interest to be considered in the judicial review of a denial of benefits under 29 U.S.C. § 1132(a)(1)(B).

(2) If the answer to the first question is "yes," the following question is presented: Whether the appropriate means to consider a conflict of interest of an insurance company in such an action is *de novo* review, a "burden shifting" test, a "sliding scale" test, or some other means.

PARTIES TO THE PROCEEDINGS BELOW

The only parties to this proceeding are named in the caption.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Elvis Kobs respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals for the Seventh Circuit (Pet. App. 1a-9a) is published at 400 F.3d 1036. The court of appeals' order denying rehearing and rehearing en banc (Pet. App. 21a) is unpublished. The opinion of the district court (Pet. App. 10a-18a) is unpublished.

JURISDICTION

The judgment of the court of appeals was entered on March 16, 2005. Petitioner's timely request for rehearing and rehearing en banc was denied on April 26, 2005. On July 11, 2005, Justice Stevens granted an extension of time in which to file the present petition until September 23, 2005. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

RELEVANT STATUTORY PROVISIONS

In relevant part, 29 U.S.C. § 1132(a)(1)(B) states:

> (a) Persons empowered to bring a civil action
>
> A civil action may be brought--
>
> (1) by a participant or beneficiary--
>
> * * *
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]

STATEMENT

This case presents the question whether an insurance company that funds and makes discretionary benefits determinations (hereinafter, a "dual-role insurer") under a plan governed by ERISA inherently acts under a conflict of interest to be considered in reviewing denials of benefits under 29 U.S.C. § 1132(a)(1)(B). Since this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), this question has deeply divided eleven circuit courts of appeal. Acknowledging this square circuit conflict, the Seventh Circuit decided in this case that a dual-role insurer does not act under such an inherent conflict.

Because, contrary to the judgment of the Seventh Circuit, a dual-role insurer does act under such an inherent conflict of interest, this case presents the additional question of whether the appropriate means to consider the conflict is *de novo* review, a "burden shifting" test, a "sliding scale" test, or some other means. The question of the appropriate consideration of a conflict of interest has also deeply divided the circuits, with at least three different prevailing approaches in effect among eleven circuit courts.

1. In January 2002, while removing Christmas ornaments from the roof of his house, 50-year-old Petitioner Elvis Kobs fell 35 feet onto concrete pavement and suffered severe injuries, including memory loss, cognitive difficulties, recurring headaches, and musculoskeletal injury to his back and legs. Pet. App. 1a, 54a-71a. At the time of his fall, Mr. Kobs was employed as a business manager at an auto dealership, earning about $85,000 per year. *Id.* at 47a-49a. Mr. Kobs was a participant in his employer's group disability plan (hereinafter, the "Plan"), which is administered by the United Wisconsin Insurance Company ("UWIC"). *Id.* at 1a. UWIC is a dual-role insurer in that it administers the

Plan, including making benefit determinations, and is financially responsible for paying benefits. *Id.* at 5a.

Mr. Kobs applied for and received short-term disability benefits from UWIC for a period of six months. *Id.* at 3a. He subsequently applied for long-term benefits, because he could not perform the material duties of his regular occupation due to the severe injuries suffered from his fall. *Id.* at 3a, 34a. Based on his salary, long-term benefits payments would have totaled more than $4,700 per month, amounting to approximately $110,000 during the first 24 months of the long-term benefit period and potentially an additional $710,000 over the remaining term of the policy. *Id.* at 33a-34a, 39a, 47a-49a (stating that benefits are two-thirds of original salary and are paid until age 65).

Several months after UWIC ceased payment of benefits, Mr. Kobs attempted to work as a loan officer but had "trouble doing the paperwork . . . such as organizing the mortgage application file in the proper sequence," and was asked to resign after three months. *Id.* at 60a, 82a.

On October 22, 2002, UWIC denied long-term benefits based upon the opinion of a physician hired by UWIC who reviewed Mr. Kobs's medical records but never directly examined him. *Id.* at 50a-53a, 88a-90a. Pursuant to an internal appeal by Mr. Kobs, UWIC thereafter considered additional evidence. *Id.* at 3a. The record on appeal included three opinions of physicians who directly examined Mr. Kobs and diagnosed him with physically and cognitively disabling conditions.[1] Three opinions

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[1] Dr. Neal Melby, Mr. Kobs's primary care physician, diagnosed Mr. Kobs with musculoskeletal injury and cognitive disability, including memory loss, and stated that Mr. Kobs is "chronically disabled and . . . unable to pursue gainful employment." Pet. App. 54a-61a. Dr. Mary Fisher, a psychologist, concluded that Mr. Kobs suffered "from deficits in executive functioning including sequencing,

from examining physicians and a psychologist, one hired by UWIC and another by a workers' compensation insurer, supported UWIC's position.[2] UWIC also hired two additional physicians and one nurse, not to conduct examinations of Mr. Kobs, but merely to review his medical records. *Id.* at 88a-91a. Each of these UWIC-retained reviewers supported UWIC's position. *Id.*

On September 4, 2003, despite the medical opinions of three examining physicians who concluded that Mr. Kobs suffered from disabling conditions, UWIC upheld the denial of benefits, stating that it "lack[ed] objective medical evidence to support the numerous subjective complaints and [found] no basis for a physically disabling condition." *Id.* at 92a-94a.

Having exhausted his appeals within UWIC, Mr. Kobs filed suit in Wisconsin state court to compel payment of

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planning, mental organization, and mental control" and met "the criteria for a DSM-IV diagnosis of dementia due to traumatic brain injury." *Id.* at 62a-67a. Dr. Thomas Reiser, an orthopedic surgeon who treated Mr. Kobs, performed an examination in May 2002 and diagnosed him with "cervical" and "lumbar" conditions constituting a "permanent partial disability to the body as a whole . . . ." *Id.* at 68a-71a.

[2] Dr. Nolan Segal stated that "[i]t does appear that [Mr. Kobs] had a significant change in his overall abilities to function on several levels following his home-related fall of January 2002," but opined that Mr. Kobs was not disabled from a "musculoskeletal standpoint." *Id.* at 72a-75a. Dr. Mary Sullivan, a psychologist, diagnosed Mr. Kobs with a "psychological disturbance . . . which would render it difficult for him to be a fully engaged worker." *Id.* at 79a. Nonetheless, she concluded that he was not "cognitively disabled or memory impaired." *Id.* at 76a-80a. Dr. Sullivan also noted that she believed Mr. Kobs's "performance" on her evaluations "raise[d] questions about the effort he exerted," but she concluded that Mr. Kobs had not acted "deliberately, e.g., with the intent to deceive." *Id.* at 77a-78a. Philip Sarff, Ph.D., a psychologist hired directly by UWIC, stated that Mr. Kobs's "pattern of deficits is not consistent with degenerative dementia." *Id.* at 81a-86a.

his long-term disability benefits. *Id.* at 1a. UWIC then removed to federal district court.[3] *Id.* As part of his discovery efforts, Mr. Kobs requested a deposition of a UWIC employee in order to determine whether UWIC acted under "a perpetual conflict." Mr. Kobs argued that pursuant to this Court's decision in *Firestone*, a heightened standard of review was warranted in such instance. *Id.* at 105a. UWIC moved for a protective order, which the district court granted, stating that it was "of the opinion that a deposition is not required to determine the administration [sic] record in this matter."[4] *Id.* at 19a. Without the benefit of further discovery, Mr. Kobs's case proceeded to summary judgment solely on the basis of the administrative record before UWIC. *Id.* at 12a-14a.

In separate proceedings, Washington Mutual Bank and Daimler Chrysler Services filed suit in state court against Mr. Kobs and his wife to foreclose on their home and to reclaim their car.[5] *Id.* at 95a-99a. Both lending institutions were ultimately successful, and Mr. and Mrs. Kobs lost their house and car. *Id.* at 100a-103a.

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[3] Jurisdiction in the district court was founded upon 29 U.S.C. § 1132(e)(1) and 28 U.S.C. § 1331. *Id.* at 10a.

[4] UWIC's motion relied upon *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 981-82 (7th Cir. 1999), which held that under a highly deferential arbitrary and capricious standard, "[t]here should not have been any inquiry into the thought processes of [the dual-role insurer's] staff . . . ." Pet. App. 107a-109a.

[5] Pursuant to Supreme Court Rule 32.3, Petitioner has written to the Clerk of this Court proposing to lodge certified copies of the state court complaints and judgments, which are a proper subject of judicial notice. *See generally* Fed. R. Evid. 201; Robert L. Stern et al., *Supreme Court Practice* 651-52 (8th ed. 2002).

In an order issued on May 28, 2004, the district court granted summary judgment in favor of UWIC. *Id.* at 18a. The district court first noted that the Plan provided UWIC "discretion to determine plaintiff's eligibility for benefits . . . ." *Id.* at 15a. Citing this Court's decision in *Firestone*, the district court found that in view of UWIC's conferred discretion, the highly deferential "arbitrary and capricious" standard applied to review UWIC's denial of benefits. *Id.* Although the district court recognized that under *Firestone* "[t]he presence of an apparent conflict of interest is a factor to be weighed when deciding whether an administrator's decision was arbitrary and capricious," *id.* (citing *Firestone*, 489 U.S. at 115), it remarked that "the Seventh Circuit has observed that conflict of interest concerns are minimal in the typical insurance context," *id.* at 16a (citing *Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406, 408-90 (7th Cir. 2004)). The court then applied the highly deferential arbitrary and capricious standard and granted summary judgment in favor of UWIC. *Id.* at 18a.

2. On March 16, 2005, the Seventh Circuit affirmed on substantially similar grounds. *Id.* at 9a. Relying on its opinions in *Leipzig* and *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998), the court of appeals rejected Mr. Kobs's contention that UWIC acted under "an inherent conflict of interest due to its dual role as insurer and administrator of the Plan." Pet. App. at 5a-6a. Although it acknowledged the circuit split on the issue, the panel remarked that the Seventh Circuit "'presume[s] that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict.'" *Id.* (quoting *Mers*, 144 F.3d at 1020).

The Seventh Circuit then reviewed UWIC's decision under the highly deferential "arbitrary and capricious standard," articulating its judicial role as one limited to

determining "whether the administrator's decision was *completely unreasonable*." *Id.* at 6a-8a (emphasis added). Without considering the effect of UWIC's conflict of interest on its denial of Mr. Kobs's benefits, the Seventh Circuit relied on the medical reports in favor of UWIC's position to conclude that the denial was not "completely unreasonable." *Id.* The court of appeals expressly commented on the importance of the standard of review to its judgment: "A more fundamental problem with Kobs' arguments is that he fails to account for the deferential standard of review that we apply to UWIC's decision." *Id.* at 9a.

On March 30, 2005, Petitioner timely sought rehearing and rehearing en banc, which the Seventh Circuit denied.[6] *Id.* at 21a. This petition followed.

REASONS FOR GRANTING THE WRIT

Eleven circuits are divided over whether a dual-role insurer acts under an inherent conflict to be considered in the judicial review of a denial of benefits. Moreover, the circuits are split as to the appropriate means to consider such a conflict of interest. This division of authority frustrates ERISA's core aim "to provide a *uniform* regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 124 S. Ct. 2488, 2495 (2004) (emphasis added). The lack of uniformity is of serious consequence to the millions of employees and their dependents who participate in ERISA plans and affects the adjudications of thousands of cases filed each

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[6] On April 21, 2005, the Social Security Administration awarded Mr. Kobs disability benefits, finding that he "has been disabled since January 3, 2002." *Id.* at 22a-31a. Pursuant to Supreme Court Rule 32.3, Petitioner has written to the Clerk proposing to lodge certified copies of the decision, which is a proper subject of judicial notice. *See* Fed. R. Evid. 201.

year to recover benefits due. The Seventh Circuit's decision also conflicts with the rationale of this Court's decision in *Firestone* and the objectives of ERISA.

I. The Circuit Courts Are Intractably Divided Over the Questions Presented

ERISA is a comprehensive statute governing employee pension and welfare programs.[7] At the time of ERISA's enactment, participation in private employer benefit programs had been growing for a hundred years, and with this increased popularity had come increased awareness of potential abuses.[8] A principal policy objective of ERISA is to eliminate these abuses by "protect[ing] . . . the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(c).

Private benefits plans governed by ERISA may be structured in a variety of fashions:

> First, the employer may fund a plan and pay an independent third party to interpret the plan and make plan benefits determinations. Second, the employer may establish a plan, ensure its liquidity, and create an internal benefits committee vested with the discretion to interpret the plan's terms and administer benefits. Third, the employer may pay an independent insurance company to fund, interpret, and administer a plan.

Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 383 (3d Cir. 2000). The present case involves the third structure.

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[7] Pub. L. No. 93-406, 88 Stat. 832 (1974) (codified as amended at 29 U.S.C. § 1001 et seq.).

[8] *See, e.g.*, Paul J. Schneider & Barbara W. Freedman, *ERISA: A Comprehensive Guide* §§ 1.02-1.05 (2d ed. 2003).

Under 29 U.S.C. § 1132(a)(1)(B), if an ERISA administrator denies benefits, a claimant may file suit "to recover benefits due to him under the terms of his plan . . . ." No statutory provision dictates the standard of review to be afforded under this section, and the courts have historically fashioned applicable standards.

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court clarified conflicting lower court case law concerning the appropriate standard of review in certain § 1132(a)(1)(B) actions. This Court held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115.

If discretion is provided, this Court noted in dicta that "[t]rust principles make a deferential standard of review appropriate . . . ." *Id.* at 111. *Firestone* further states in dicta, that if a "benefit plan" subject to ERISA "gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion'" by the administrator.[9] *Id.* at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)).

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[9] The "abuse of discretion" standard discussed by this Court in *Firestone* emanates from trust law, whereas the "arbitrary and capricious" standard that the Seventh Circuit applied in this case derives from administrative law. Despite *Firestone*'s reliance on trust principles, most circuit courts have equated the two standards in the ERISA context. *E.g.*, *Wright v. R. R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74 (1st Cir. 2005).

A. There Is A Deep Split Among The Circuits Over Whether A Dual-Role Insurer Is Subject To An Inherent Conflict To Be Considered In The Judicial Review Of A Denial Of Benefits

Since *Firestone*, the courts of appeals have taken different approaches on whether the denial of benefits by "insurance companies that both fund a plan and are also ERISA plan administrators" involves an inherent conflict to be considered in the judicial review of a particular denial of benefits under § 1132(a)(1)(B). *Pinto*, 214 F.3d at 378 (examining the split in detail and cataloguing cases).

1. The majority of the circuits addressing the issue, including the Third, Fourth, Fifth, Sixth, Tenth, and Eleventh, have held that a dual-role insurer[10] is subject to an inherent conflict to be considered in judicial review. *Pinto*, 214 F.3d at 387-90; *Vega v. Nat'l Life Ins. Serv., Inc.*, 188 F.3d 287, 295-98 (5th Cir. 1999) (en banc); *Pitman v. Blue Cross & Blue Shield of Okla.*, 24 F.3d 118, 120-22 (10th Cir. 1994); *Doe v. Group Hospitalization v. Med. Servs.*, 3 F.3d 80, 86 (4th Cir. 1993); *Miller v. Metropolitan Life Ins.*, 925 F.2d 979, 984-85 (6th Cir. 1991);[11] *Brown v. Blue Cross & Blue Shield of Ala.*, 898 F.2d 1556, 1561 (11th Cir. 1990).

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[10] This petition uses the term "insurer" generically—i.e., to encompass any non-employer fiduciary that both administers and funds a plan by providing insurance-type benefits, such as traditional insurance companies, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and the like.

[11] The Sixth Circuit has not been entirely uniform. *See, e.g., Yeager v. Reliance Standard*, 88 F.3d 376, 381-82 (6th Cir. 1996) (failing to consider how the conflict of interest affected the dual-role insurer's specific denial of benefits). In the last five years, however, the Sixth Circuit has followed the majority approach in its published opinions. *See Gismondi v. United Techs. Corp.*, 408 F.3d 295, 298-99

Courts recognizing that there is an inherent conflict of a dual-role insurer to be considered in judicial review emphasize the fiduciary nature of the insurer's relationship to the beneficiary, and how the insurer's profit motives interfere with that relationship of trust. As the Fourth Circuit explained in *Doe*:

> Undoubtedly, [the insurer's] profit from the insurance contract depends on whether the claims allowed exceed the assumed risks. To the extent that [the insurer] has discretion to avoid paying claims, it thereby promotes the potential for its own profit .... Even the most careful and sensitive fiduciary in those circumstances may unconsciously favor its profit interest over the interests of the plan, leaving beneficiaries less protected than when the trustee acts without self-interest and solely for the benefit of the plan.

3 F.3d at 86-87. *See also Vega*, 188 F.3d at 295-98; *Armstrong*, 128 F.3d at 1265; *Pitman*, 24 F.3d at 120-22; *Brown*, 898 F.2d at 1561.

In contrast, the First, Second, and Seventh Circuits hold that there is no inherent conflict of a dual-role insurer that should be considered in ıe judicial review of a specific denial of benefits. These circuits require an additional evidentiary showing beyond the dual-role relationship itself.[12] *Mers* 144 F.3d at 1020-21; *Doyle v.*

(6th Cir. 2005); *Carr v. Reliance Std. Life Ins. Co.*, 363 F.3d 604, 606 n.2 (6th Cir. 2004); *Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 527-28 (6th Cir. 2003).

[12] The Seventh Circuit requires that a "claimant show[] by providing specific evidence of actual bias that there is a significant conflict." *Mers*, 144 F.3d at 1020. Application of this requirement, along with the Seventh Circuit's decision in *Perlman*, *see supra* note 4, had a Kafkaesque result in this case. In order for the conflict to be

Paul Revere Life Insurance Co., 144 F.3d 181, 184 (1st Cir. 1998); *Whitney v. Empire Blue Cross & Blue Shield*, 106 F.3d 475, 477-78 (2d Cir. 1997) (citing *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 440-44 (2d Cir. 1995)).[13] In concluding that the conflicting fiduciary obligations of a dual-role insurer need not be taken into account in judicial review, these circuits have relied on unsubstantiated economic assumptions regarding the significance of the insurer's conflicting duties.[14] *See, e.g.*, *Mers*, 144 F.3d at 1021.

The Eighth Circuit originally adopted the majority approach, *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997), but later crafted a two-step hybrid approach for determining whether a conflict of interest should be considered, *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160-61 (8th Cir. 1998). Under the *Woo* test, a claimant must show "that (1) a palpable conflict of

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considered by the district court, it needed to be demonstrated by the introduction of specific evidence in the sole possession of the insurer. But the district court denied Mr. Kobs discovery on this issue based on its view that review must be limited to the administrative record under the arbitrary and capricious standard. *Id.* at 19a-20a.

[13] *But see Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2d Cir. 2000) (suggesting that a dual-role insurer is under a conflict that should "be weighed in determining whether there has been an abuse of discretion") (internal quotation marks and citations omitted). Despite *Pulvers*, cases within the Second Circuit continue to apply the arbitrary and capricious standard set forth in *Whitney*. *E.g.*, *Kirk v. Readers Digest Ass'n*, 57 Fed. Appx. 20, 25 (2d Cir. 2003).

[14] For instance, in *Mers*, the Seventh Circuit asserted, without reference to evidentiary support, that because the insurer's overall revenue was so large, the small payout would not provide enough of an incentive for self-dealing. *Mers*, 144 F.3d at 1021. The Seventh Circuit in *Mers* also supposed, again without evidentiary support, that it is in an insurer's long-term interest to grant meritorious claims so that employers and employees are sufficiently motivated to contract with the insurer. *Id.*

interest or a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to her." *Id.* at 1160. Both *Woo* and later Eighth Circuit cases consider "evidence" that an ERISA administrator is a dual-role insurer sufficient to meet the first step of the test. *Id.*; *Schatz v. Mutual of Omaha Ins. Co.*, 220 F.3d 944, 947-48 (8th Cir. 2000). Unlike the majority approach, however, to satisfy the second part of the test, the claimant must "show that the conflict . . . has some connection to the substantive decision reached." *Woo*, 144 F.3d at 1161 (internal quotation marks and citations omitted).

Finally, the Ninth Circuit has published inconsistent panel opinions on the issue. In *Atwood v. Newmont Gold*, 45 F.3d 1317, 1322-23 (9th Cir. 1995), the Ninth Circuit concluded that in the absence of "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self interest caused a breach of the administrator's fiduciary obligations to the beneficiary," a conflict of interest need not be considered in judicial review of benefits denials. *Id.* at 1323. *See also Snow v. Standard Ins. Co.*, 87 F.3d 327, 331 (9th Cir. 1996). Yet, in *Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 976 (9th Cir. 1999), the court held that, even in the absence of specific evidence, "less deferential" review was warranted for a dual-role insurer.

2. This circuit split and its attendant confusion will not be resolved without this Court's intervention. The Seventh Circuit, despite being squarely in conflict with six circuits, declined in this case to reconsider its position en banc. Although a published opinion of the Second Circuit has expressed criticism of prior circuit precedent, *DeFelice v. American Int'l Life Assur. Co. of New York*, 112 F.3d 61, 66 n.3 (2d Cir. 1997), the Second Circuit has not undertaken full en banc review, *Kirk*, 57 Fed. Appx. at 25. The First Circuit has repeatedly applied its ruling

in *Doyle* and has also shown no inclination for en banc review. *See Wright v. R. R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 76 n.5 (1st Cir. 2005).

The views of the other circuits are also generally settled. The Fifth Circuit has already decided the issue en banc. *Vega*, 188 F.3d at 295-98. Three other circuits (the Sixth, Eighth, and Tenth) have denied requests for en banc rehearing on the issue.[15] The Third, Fourth, and Eleventh circuits have repeatedly applied the majority approach.[16] In contrast, the Ninth Circuit remains internally divided.[17]

This Court adverted to the unresolved question in *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355, 384 n.15 (2002) ("It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest."). *See also* Transcript of Oral Argument at *6-*11 & *21, *Black & Decker Disability Plan v. Nord*, 538

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[15] *Peach v. Ultramar Diamond Shamrock*, 109 Fed. Appx. 711 (6th Cir. 2004), *reh'g en banc denied* (Sept. 30, 2004), *cert. denied*, 125 S. Ct. 1641 (2004); *Glenn v. Life Ins. Co. of N. Am.*, 240 F.3d 679 (8th Cir. 2001), *reh'g and reh'g en banc denied* (Apr. 23, 2001), *cert. denied*, 534 U.S. 893 (2001); Petition for Writ of Certiorari, *Fought*, *cert. denied*, 125 S. Ct. 1972 (May 2, 2005) (No. 04-1000), 2005 WL 190349 at *6 (noting the denial of rehearing en banc).

[16] *See Kosiba v. Merck & Co.*, 384 F.3d 58, 64-66 (3d Cir. 2004) (examining "Pinto and Its Progeny"), *cert. denied sub nom. Merck & Co. v. Epps-Malloy*, 125 S. Ct. 2252 (2005); *Stup v. UNUM Life Ins. Co. of Am.*, 390 F.3d 301, 307 (4th Cir. 2004) (citing *Doe* and following cases); *Williams v. BellSouth Telecomms., Inc.*, 373 F.3d 1132, 1135 (11th Cir. 2004) (same).

[17] *Compare Alford v. Dch Found. Group Long-Term Disability Plan*, 311 F.3d 955 (9th Cir. 2002) (applying the *Atwood* standard that there is no conflict to be considered in the absence of specific evidence) *with Nord v. Black & Decker Disability Plan*, 356 F.3d 1008 (9th Cir.) ("The district court recognized the apparent conflict of interest and reviewed the Plan administrator's decision with the special care required by *Firestone*."), *cert. denied*, 125 S. Ct. 62 (2004).

U.S. 822 (2003) (No. 02-469), 71 U.S.L.W. 3695, 2003 WL 21006122 (repeated questioning on the issue at oral argument).

Not only are ERISA participants and beneficiaries harmed by this unsettled question. In the interest of uniformity, two of the largest insurance industry trade organizations have expressed their desire to resolve the issue:

> Of substantial concern to *amici* and their members is the ongoing conflict and confusion among the circuit courts of appeals regarding the standard of review applicable to actions under ERISA alleging wrongful denial of benefits when an insurer, or any other administrator or fiduciary, is operating under a conflict of interest.

Motion of America's Health Insurance Plans and the American Council of Life Insurers to File a Brief Amici Curiae in Support of the Petition and Brief Amici Curiae at 5, *Fought v. Unum Life Ins. Co. of America*, *cert. denied*, 125 S. Ct. 1972 (May 2, 2005) (No. 04-1000), 2005 WL 1334150.[18]

Finally, despite the vast number of cases discussing this widespread and important split, neither Congress by statute nor the Department of Labor by regulation has

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[18] The petition for certiorari in *Fought* was filed after the Tenth Circuit reversed and remanded a district court decision that had originally granted summary judgment to the issuer. *Fought v. Unum Life Ins. Co. of America*, 379 F.3d 997, 1015 (8th Cir. 2004). As a result, there was no final judgment. *Id.* *Fought* also presented complex tangential issues, making it a poor vehicle for review. *See id.* at 1011-15.

resolved it.[19] In similar circumstances in *Firestone*, this Court recognized the need for judicial resolution, because "ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) . . . ." 489 U.S. at 109.

3. This case provides an ideal vehicle to resolve this circuit split. The judgment of the Seventh Circuit is final, Pet. App. 1a, 21a, the medical evidence is in conflict, and the Seventh Circuit expressly stated that its "deferential" standard of review was material to its decision, *id.* at 9a. By failing to consider the effect of UWIC's conflict of interest on its denial of Mr. Kobs's benefits, the Seventh Circuit used a highly deferential arbitrary and capricious standard. *Id.* at 5a-6a. In so doing, it found in UWIC's favor on summary judgment, despite the existence of what—under tests from other circuits—would qualify as genuine issues of material fact as to Mr. Kobs's medical condition. *See Pinto*, 214 F.3d at 393-95 (finding that summary judgment was inappropriate under a "heightened" arbitrary and capricious standard where physicians' opinions conflicted and "a factfinder could conclude that [the insurer's] decision to credit its doctors . . . was the result of self-dealing instead of the result of a trustee carefully exercising its fiduciary duties"); *Tremain*, 196 F.3d at 978 (holding under a less deferential standard that "[b]ecause there are genuine issues of material fact in dispute as to whether Tremain was disabled and as to whether she was a 'salesman,' her entitlement to benefits and the amount of those benefits may not be decided by summary judgment").

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[19] Although the Secretary of Labor has issued regulations governing claims and determinations, including appeals of adverse benefit determinations, these regulations are silent on the proper standard of judicial review. *See* 29 C.F.R. 2560.503-1.

Finally, this case does not contain procedural irregularities or predicate factual or legal issues that would prevent this Court from reaching this question.

B. There Is A Three-Way Split Among Eleven Circuits Over What Approach Applies When A Conflict Is Present

1. When a conflict of interest is present, regardless of whether the ERISA fiduciary is an insurance company, and regardless of how that conflict is shown, the circuits have adopted three different means (and variants thereof) by which to consider a conflict of interest: [20]

a. "Sliding Scale" Tests

The Third, Fourth, Fifth, Sixth, and Seventh Circuits have consistently implemented a "sliding scale" test to consider a conflict of interest. Under this approach, generally "deference [is] lessened to the degree necessary to neutralize any untoward influence resulting from the conflict." *Doe v. Group Hospitalization & Medical Services*, 3 F.3d 80, 87 (4th Cir. 1993); *accord Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000); *Vega v. National Life Ins. Services, Inc.*, 188 F.3d 287, 296 (5th Cir. 1999) (en banc); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 n.1 (7th Cir. 1998); *Miller v. Metropolitan*

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[20] The second question presented concerns the appropriate means to consider the conflict of interest specifically of an insurer. *See supra* at i. There is a significant circuit split on this issue. *Compare, e.g., Doe*, 3 F.3d at 87; *Pinto*, 214 F.3d at 392; *Vega*, 188 F.3d at 287 (adopting sliding scale test) *with Brown*, 898 F.2d at 1566 (adopting burden shifting test) *with Fought*, 379 F.3d at 1004 (adopting modified burden shifting test). This section of the petition also discusses some cases involving non-insurers, as the circuits have generally not distinguished between insurers and non-insurers once a conflict is shown. *E.g., Yochum v. Barnett Banks Inc.*, 234 F.3d 541, 543-44 (11th Cir. 2000) (applying burden shifting approach of *Brown* to conflicted employer-fiduciary).

Life Ins. Co., 925 F.2d 979, 984 (6th Cir. 1991). The First Circuit has adopted a "reasonableness" test, *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999), which is "something like the sliding scale" approach, *Pinto*, 214 F.3d at 392.[21]

b. "Burden Shifting" Tests

The Eleventh Circuit was the first to adopt a "burden shifting" approach. Under this test, "when a plan beneficiary demonstrates a substantial conflict of interest . . . the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest." *Brown v. Blue Cross & Blue Shield of Ala.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990). Unlike a highly deferential arbitrary and capricious standard of review that does not take into account a conflict, under a burden shifting approach, "a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries." *Id.* at 1568.[22]

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[21] The "sliding scale" courts typically focus on this Court's dicta in *Firestone* that the "conflict must be weighed as a factor in determining whether there is an abuse of discretion," 489 U.S. at 115 (internal quotation marks and citations omitted). *E.g.*, *Pinto*, 214 F.3d at 392 (noting derivation of sliding scale test from "*Firestone*'s dictate that a conflict should be considered as a 'factor' in applying the arbitrary and capricious standard"). The *Pinto* court itself, however, criticized the workability of this approach: "Once the conflict becomes a 'factor' however, it is not clear how the process required by the typical arbitrary and capricious review changes." *Id.*

[22] In adopting a "burden shifting" standard, the Eleventh Circuit relied on general principles of trust law. *Id.* at 1563-68. *Cf. Pinto*, 214 F.3d at 393 ("While the approach of . . . the Eleventh Circuit would seem more compatible with the basic principles of trust law, and hence

The Ninth Circuit applies a variant of the Eleventh Circuit's burden shifting test in situations where the claimant presents specific "evidence indicating that the conflicting interest caused a breach of the administrator's fiduciary duty." *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995).[23]

The Tenth Circuit in *Fought* provided substance to its "sliding scale" test to specifically answer the question of "how much less deference ought a reviewing court afford?" 379 F.3d at 1004. In so doing, the *Fought* court effectively bifurcated its sliding scale test into two tiers: first, "standard" conflicts of interest, wherein the conflict is considered as "one factor" in the overall review; and second, "inherent" conflicts (such as those of dual-role insurers), wherein the burden shifts to the plan administrator to "demonstrate that its interpretation of the terms of the plan is reasonable and that its application of those terms to the claimant is supported by substantial evidence." *Id.* at 1005-06.

c. *De Novo* Review

The Second Circuit—although finding a conflict only in the presence of particularized evidence of such—adopts a *de novo* review of any denials of benefits once a showing of a conflict is made. *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996). Under the pure *de novo* approach of the Second Circuit, there is

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a better 'fit', only the Supreme Court can undo the legacy of *Firestone*.").

[23] In cases finding an inherent conflict where no additional evidence has been presented, *see supra* Part I.A., the Ninth Circuit has indicated that a "less deferential" standard of review (though not burden shifting) is appropriate. *Tremain*, 196 F.3d at 976; *accord Nord*, 356 F.3d at 1008.

no burden shifting; rather, if a conflict of interest is shown, "the court interprets the plan *de novo*." *Id.*

The Eighth Circuit adopted a *de novo* standard in *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997).[24] Yet, in *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998), the court distinguished *Armstrong* as a case involving "egregious circumstances" and adopted a sliding scale test. The Eighth Circuit has not settled on a single approach. *See, e.g.*, *Harden v. Am. Express Fin. Corp.*, 384 F.3d 498, 500 (8th Cir. 2004) (endorsing sliding scale review); *Davolt v. Executive Comm. of O'Reilly Auto.*, 206 F.3d 806, 809 (8th Cir. 2000) (endorsing *de novo* and sliding scale standards).

2. Like the first question presented in this case, *see supra* Part I.A, this circuit split will not resolve itself without this Court's intervention. The circuits have applied these tests for many years, and a number of circuits have either decided the issue en banc or have rejected requests for rehearing en banc.[25] This Court's comments in *Rush Prudential* highlight the question of just what standard of review should apply in the face of a conflict. 536 U.S. at 384 n.15.

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[24] In *Armstrong*, the Eighth Circuit articulated its rationale for a *de novo* standard as "informed by the reasoning of the Eleventh Circuit's holding in *Brown*, which stated that a relationship that places an ERISA benefits plan administrator in 'perpetual conflict' warrants a higher level of scrutiny." 128 F.3d at 1265 (quoting *Brown*, 898 F.2d at 1561).

[25] *E.g.*, *Stup*, 390 F.3d at 307 (noting repeated application); *Kosiba*, 384 F.3d at 64-66 (same); *HCA Health Services of Georgia, Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 993-94 (11th Cir. 2001) (same); *Vega*, 188 F.3d at 295-98 (en banc decision); Petition for Writ of Certiorari, *Fought*, 2005 WL 190349 at *6 (noting refusal to reconsider en banc).

3. Like the first question presented, a decision on this second question will be material to the outcome of the present case. Specifically, if a conflict of interest is not considered, a plan fiduciary is granted significant deference such that evidence contradictory to that relied upon by the fiduciary will not typically create a genuine issue of material fact. *See supra* Part I.A. On the other hand, without such deference, contradictory evidence will often create a genuine issue of material fact so as to preclude summary judgment. *See id.* In view of the directly contradictory evidence in this case, and the likely role that UWIC's conflict of interest played in its denial of benefits, summary judgment in UWIC's favor was not appropriate.[26]

Because the facts here squarely present the issue and the case law in this area is well-developed, this Court should endeavor to resolve just how "peeled" the "judicial eye" should be in light of a conflict of interest.[27] *Rush Prudential*, 536 U.S. at 384 n.15.

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[26] Under a burden shifting or *de novo* approach, the conflicting evidence in the record under review would preclude summary judgment. *E.g.*, *Tremain*, 196 F.3d at 978. Under a "sliding scale" approach, whether summary judgment is appropriate depends in part on the level of deference accorded to the fiduciary. *E.g.*, *Pinto*, 214 F.3d at 392.

[27] In so doing, this Court need not determine under the proper standard whether summary judgment was appropriate in this case. When deciding upon the appropriate standard of review, this Court has routinely determined the correct standard and then remanded the case to the circuit or district court to apply the proper standard "in the first instance." *Johnson v. California*, 125 S. Ct. 1141, 1152 (2005) (determining that the appropriate standard of review was "strict scrutiny" and remanding "the case to allow the Court of Appeals for the Ninth Circuit, or the District Court, to apply it in the first instance").

II. The Questions Presented Are Frequently Litigated And Of Manifest National Importance

A. Each Year, There Are Millions Of ERISA-Governed Benefits Determinations, Resulting In Thousands Of Lawsuits Challenging Denials Of Benefits

Resolution of the questions presented is of significant national importance. In 2005, according to the Bureau of Labor Statistics, Department of Labor, of roughly 110 million private employees nationwide, approximately 53% participated in health care plans; 50% in retirement benefits plans; 49% in life insurance plans; 39% in short-term disability plans; and 29% in long-term disability plans.[28] The total payout in 2004 under private pension, profit-sharing, and insurance plans was nearly $950 billion, approximately 8% of the U.S. gross domestic product that year.[29] Most of these plans are subject to ERISA. *See* 29 U.S.C. § 1002(1).

The Department of Labor estimates that ERISA fiduciaries and administrators deny more than 40 million

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[28] Total Private Employment – Not Seasonally Adjusted, U.S. Department of Labor, Bureau of Labor Statistics, http://data.bls.gov/cgi-bin/surveymost?ce (last visited Sept. 21, 2005); National Compensation Survey: Employee Benefits in Private Industry in the United States, U.S. Department of Labor, Bureau of Labor Statistics 6, 9 (Mar. 2005), *available at* http://www.bls.gov/ncs/ebs/sp/ebsm0003.pdf.

[29] *See* Employer Contributions for Employee Pension and Insurance Funds by Industry and by Type, U.S. Department of Commerce, Bureau of Economic Analysis, http://www.bea.gov/bea/dn/nipaweb/TableView.asp?SelectedTable=208&FirstYear=2003&LastYear=2004&Freq=Year (last visited Sept. 21, 2005); Current-Dollar and "Real" Gross Domestic Product, U.S. Department of Commerce, Bureau of Economic Analysis, http://www.bea.gov/bea/dn /gdplev.xls (last visited Sept. 21, 2005).

claims annually. *See* Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure, 65 Fed. Reg. 70246, 70263 (Nov. 21, 2000). In 2003 alone, 750 lawsuits were filed in federal court under ERISA against just one of the nation's many dual-role insurers, UnumProvident.[30]

B. The Objectives Of ERISA To Promote Uniformity And To Protect Private Employee Benefits Are Thwarted By The Decision Below

The inconsistent decisions concerning the proper approach for reviewing denials of benefits by dual-role insurers contravenes ERISA's aim of providing a uniform, nationwide system of employee benefits. *See Aetna Health*, 124 S. Ct. at 2495. In the aggregate, insurers, employers, and employees needlessly suffer, because the lack of clear legal principles in this area unnecessarily raises costs for all parties. *Cf. FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) ("To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits."). A clear and workable set of rules will remove these burdensome costs

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[30] The number of suits filed was determined by running a search on Lexis-Nexis Courtlink, available at http://www.courtlink.com, in all federal district courts for ERISA cases filed in 2003 with "Unum" or "UnumProvident" named as a defendant. Based on accounts of UnumProvident's recent settlement with the U.S. Department of Labor and many states regarding disability claims handling, it appears most of those cases are appeals of discretionary adverse benefit determinations under ERISA. *See, e.g.*, Peter A. Meyers, Comment, *Discretionary Language, Conflicts of Interest, and Standard of Review for ERISA Disability Plans*, 28 Seattle U. L. Rev. 925-927 (2005) (describing lawsuits against UnumProvident appealing denials of disability benefits under apparently discretionary plans).

by providing an across-the-board standard that insurers and employers can implement to gauge costs and provide maximal benefits to employees per dollar spent.

A clear and workable rule, however, need not provide effectively unbridled deference to a conflicted plan administrator. Another aim of ERISA, of course, is the accurate determination of benefit claims. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (noting ERISA's enforcement provision reflects "a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans"). While ignoring the presence of a conflict certainly provides consistency and uniformity, it gives unwarranted immunity for insurers to reject meritorious claims. *Cf. Pinto*, 214 F.3d at 388 ("insurance carriers have an active incentive to deny close claims in order to keep costs down and keep themselves competitive so that companies will choose to use them as their insurers, an economic consideration overlooked by the Seventh Circuit."). ERISA was enacted to safeguard against these very abuses. *See Firestone*, 489 U.S. at 113 ("ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits.").

Moreover, the Seventh Circuit's holding contravenes this Court's reliance in *Firestone* upon the common law of trusts as the appropriate framework to ensure that administrators follow their fiduciary obligations such that self-interest does not infect claims determinations. *Id.* at 110-11. An insurance company administering a benefits plan, like any trustee, is a fiduciary subject to both a duty of loyalty, 29 U.S.C. § 1104(a)(1)(A), and a duty of care, *id.*

§ 1104(a)(1)(B).[31] Under trust law principles any conflict that may compromise these duties justifies either voiding a decision tainted by the conflict or applying more scrutiny in reviewing such a decision.[32] Although ERISA contains an exception to the usual rule of trust law in order to allow dual-role insurers to administer plans, 29 U.S.C. § 1108(c)(3), that exception does not imply that conflicted insurers should receive the same level of deference as impartial fiduciaries.[33]

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[31] *See also Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570-72 (1985) ("The manner in which trustee powers may be exercised, however, is further defined in the [ERISA] statute through the provision of strict standards of trustee conduct, also derived from the common law of trusts – most prominently, a standard of loyalty and a standard of care."); *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329-332 (1981) (finding that ERISA imposes "an unwavering duty of complete loyalty to the beneficiary of the trust, to the exclusion of the interests of all other parties"). *Cf. Meinhard v. Salmon*, 164 N.E 545, 546 (N.Y. 1928) (Cardozo, J.) ("A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior.").

[32] *See* Restatement (Second) of Trusts § 170(1) cmts. a-h (1959); *id.* at § 187. *Cf.* G. Bogert, *Trusts and Trustees* § 543, at 475-76 (2d ed. 1960) ("[I]t is generally, if not always, humanly impossible for the same person to act fairly in two capacities and on behalf of two interests in the same transaction. Consciously or unconsciously he will favor one side as against the other, where there is or may be a conflict of interest."). Of course, UWIC's fiduciary officers owe a duty of loyalty and duty of care not only to plan participants, but to UWIC's profit-seeking stockholders. *E.g., Western Industries v. Vilter Mfg. Co.*, 257 Wis. 268, 299 (Wis. 1950) ("It is their duty to administer the corporate affairs for the common benefit of all the stockholders, and exercise their best care, skill and judgment in the management of the corporation business solely in the interest of the corporation.") (internal citations and quotation marks omitted).

[33] *See Doe*, 3 F.3d at 86-87 ("But this consent does not mean that the fiduciary's judgment will not be scrutinized more closely than when he acts solely in the interest of the beneficiaries.").

The Seventh Circuit's analysis rests on unsubstantiated economic assertions effectively to adopt a *per se* rule that precludes clear conflicts under trust law from being considered in the judicial review of a denial of benefits. In fact, there is economic evidence directly contradicting these assumptions. In *Armstrong*, the Eighth Circuit noted that "[a]pparently to limit claim payments, Aetna provides incentives and bonuses to its claims reviewers based on criteria that include a category called 'claims savings.'" 128 F.3d at 1265. A deposed claims manager described "claims savings" as funds retained by Aetna on claims "not eligible" for benefits.[34] Pet. App. 111a. She also explained in detail how "claims savings" played a role in determining "merit increases" (i.e., bonuses) for claims adjusters, including several of her own bonuses. *Id.* at 112a-116a.

This sort of self-serving behavior is not limited to a single insurer. For example, an internal memorandum from another major insurance company confirms that a deferential standard of review emboldens ERISA fiduciaries to deny claims in close cases:

> The advantages of ERISA coverage in litigious situations are enormous . . . . [There] are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit[s] in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant . . . *While our objective is to pay all valid claims and deny*

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[34] Pursuant to Supreme Court Rule 32.3, Petitioner has written to the Clerk proposing to lodge certified copies of the deposition filed with the court in *Armstrong*, which is a proper subject of judicial notice. *See* Fed. R. Evid. 201.

> *invalid claims, there are some gray areas, and ERISA applicability may influence our course of action.*

Id. at 117a-119a. (submitted as an exhibit to Plaintiff's Trial Brief, *Schneider v. Provident Life & Accident Ins. Co.*, No. C 97-4646 SC (N.D. Cal. Apr. 5, 1999)) (emphasis added).[35] *See also* Peter G. Gosselin, *The New Deal; The Safety Net She Believed In Was Pulled Away When She Fell*, Los Angeles Times, August 21, 2005, at A1 (describing claims adjudication practices of disability insurers).

Finally, and perhaps most importantly, the Seventh Circuit's view is directly contrary the policy objectives of ERISA to provide remedies to *individual*, injured workers. *Cf. Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996) ("ERISA specifically provides a remedy for breaches of fiduciary duty with respect to the interpretation of plan documents and the payment of claims . . . that runs directly to the injured beneficiary."). Even if, as the Seventh Circuit predicts, employers will "[i]n the long run . . . leave" an insurer that denies meritorious claims, this views fails to vindicate the rights of *current* beneficiaries. Whether Mr. Kobs's former employer continues to use UWIC as its plan administrator has no bearing on Mr. Kobs's present right to benefits.

That UWIC was under a conflict of interest in making its benefit determination, however, did have a bearing on Mr. Kobs's right. Under the rationale of this Court's decision in *Firestone*, the impact of that conflict must be

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[35] Pursuant to Supreme Court Rule 32.3, Petitioner has written to the Clerk proposing to lodge certified copies of the trial brief and exhibit, which are a proper subject of judicial notice. *See* Fed. R. Evid. 201.

"weighed" in the judicial review of UWIC's denial of benefits. Moreover, in view of the widespread divergence among the circuits over how a conflict of interest should be weighed, and the importance of national uniformity under ERISA, determining the appropriate means to consider such a conflict is crucial.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

LAURA W. BRILL
Counsel of Record
TED M. SICHELMAN
IRELL & MANELLA, LLP
1800 Avenue of the Stars
Los Angeles, California 90067
(310) 277-1010

JASON W. WHITLEY
NOVITZKE, GUST, SEMPF
& WHITLEY
314 Keller Avenue North,
Suite 399
Amery, Wisconsin 54001
(715) 268-6130

Counsel for Petitioner Elvis Kobs

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400 F.3d 1036

United States Court of Appeals,
Seventh Circuit.
Elvis KOBS, Plaintiff-Appellant,
v.
UNITED WISCONSIN INSURANCE COMPANY,
Defendant-Appellee.
No. 04-2483.

Argued Jan. 20, 2005.
Decided March 16, 2005.
Rehearing and Rehearing En Banc Denied April 26, 2005.

Jason W. Whitley (argued), Novitzke, Gust, Sempf & Whitley, Amery, WI, for Plaintiff-Appellant.

Carol L. Dorner (argued), United Wisconsin Group, Milwaukee, WI, for Defendant-Appellee.

Before FLAUM, Chief Judge, and BAUER and KANNE, Circuit Judges.

BAUER, Circuit Judge.

Plaintiff-appellant Elvis Kobs suffered injuries in January 2002 when he fell off his roof while removing Christmas ornaments. Following the accident, Kobs received short-term disability benefits from his disability insurance carrier, defendant-appellee United Wisconsin Insurance Company ("UWIC"), but his subsequent application for long-term disability benefits was denied. After an unsuccessful appeal of that determination, Kobs filed suit in state court, and UWIC removed the case to federal court, as the plan at issue is governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001, *et seq.* The district court granted summary judgment in favor of UWIC. We affirm.

I. Background

Prior to his January 2002 fall, Kobs was a business manager at Bernard's Northtown car dealership in New Richmond, Wisconsin. This sedentary job required him to sit eighty percent of the day, stand twenty percent of the day, and lift up to five pounds. Kobs was a participant in a group disability insurance plan (the "Plan") issued by UWIC to Bernard's Northtown, and the Plan offered both short-term and long-term benefits. With regard to short-term benefits, the Plan states: "You are disabled if, because of illness or injury, you are unable to perform with reasonable continuity, the material duties of the occupation that you regularly perform for this group." The Plan generally provides long-term disability benefits when an insured is "Totally Disabled," defined, in relevant part, as follows:

> **"TOTAL DISABILITY"** and **"TOTALLY DISABLED"** means that due to Injury and/or Illness:
>
> 1. The Insured cannot perform the material duties of his or her regular occupation during the Elimination Period and the following 24 months of the Benefit Period; and
>
> 2. After 24 months of the Benefit Period, the Insured cannot perform any of the material duties of any gainful occupation for which he/she is or may be reasonably fitted by education, training, or experience.

The Plan also confers discretion upon UWIC to determine eligibility for benefits:

BENEFIT DETERMINATION

Benefits under this policy will be paid only if United Wisconsin Insurance Company decides in its discretion that the Insured is entitled to them.

Kobs applied for short-term disability benefits immediately after the January 2002 accident. UWIC approved his application and paid him short-term disability from January 2, 2002, until July 4, 2002, when his short-term benefits were exhausted. Kobs then applied for long-term disability benefits. Kobs claimed that he could not perform the material duties of his regular occupation because he suffered from various conditions, most notably memory loss resulting from incidents in 1998 and 1999 and exacerbated by his fall in 2002. In an October 2002 letter, UWIC denied Kobs' claim for long-term disability benefits, explaining that "the medical information does not support an inability to perform the duties of your occupation, after July 4, 2002." After Kobs appealed the determination, UWIC received and reviewed additional medical information and then upheld the denial of benefits. The denial letter stated, "We lack objective medical evidence to support the numerous subjective complaints and find no basis for a physically disabling condition."

UWIC considered a number of medical opinions and records in arriving at its decision. The opinions weighing in Kobs' favor came from Dr. Neal Melby, his primary care physician, and Dr. Mary Fischer, a psychologist who saw Kobs on a referral from Dr. Melby. Dr. Melby opined on several occasions that Kobs was disabled both as a result of "musculoskeletal problems" (injuries to his back and legs) and as a result of cognitive disability, including memory loss. Dr. Fischer met with Kobs to evaluate his complaints of memory loss, headaches, and cognitive

difficulties. After conducting psychological tests on Kobs, she concluded that he suffered "from deficits in executive functioning including sequencing, planning, mental organization, and mental control" and "global memory deficits," and met "the criteria for a DSM-IV diagnosis of dementia due to traumatic brain injury." In addition, Dr. Thomas Reiser of the Midwest Spine Institute saw and evaluated Kobs in 1999, then reviewed Kobs' medical records in 2002 and stated that he had "a permanent partial disability of 4% to the body as a whole" under applicable workers' compensation law.

On the other side of the scale were the opinions of two orthopedic surgeons, two psychologists, a psychiatrist/neurologist, and a registered nurse. Dr. Nolan Segal, an orthopedic surgeon, performed an independent medical evaluation of Kobs in January 2003 and concluded that there was "no evidence [that Kobs] would be considered disabled from a musculoskeletal standpoint." Dr. Richard Silver, also an orthopedic surgeon, reviewed Kobs' medical file at UWIC's request and concluded that Kobs was "fit for duty at a sedentary light capacity . . . from an orthopedic perspective." Dr. Mary Sullivan, a psychologist who saw Kobs on a referral from Dr. Melby, performed a neuropsychological evaluation of Kobs in August 2003 and concluded that Kobs was not "cognitively disabled or memory impaired." Dr. Sullivan also noted that "there are numerous implausible aspects of his performance which raise questions about the effort he exerted throughout the evaluation." Dr. Reginald Givens, a psychiatrist and neurologist hired by UWIC to review Kobs' file, concluded that "Kobs does not have a significant impairment that would impair him from performing essential functions of his employment." Dr. Philip Sarff, a psychologist hired by

UWIC, evaluated Kobs in March 2003 and opined that Kobs' "pattern of deficits is not consistent with degenerative dementia, or dementia due to brain injury." In addition, Sarff noted that "there is strong evidence that [Kobs] consciously or unconsciously exaggerated symptoms for this evaluation." The final opinion came from Francine Blaha, a nurse who reviewed Kobs' entire file at UWIC's request prior to its decision on Kobs' appeal. Blaha recommended that UWIC uphold the denial of long-term disability benefits because "the objective data does not even come close to the massive subjective complaints of the claimant."

II. Discussion

Kobs leads with a challenge to the district court's decision to apply the arbitrary and capricious standard to review UWIC's benefits determination. Citing case law from other circuits, Kobs argues that UWIC has an inherent conflict of interest due to its dual role as insurer and administrator of the Plan. *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377 (3d Cir.2000) (collecting cases). We have considered and rejected similar arguments on numerous occasions, most recently in *Leipzig v. AIG Ins. Co.*, 362 F.3d 406 (7th Cir.2004), and we see little reason to revisit those opinions or add to their analysis. As we explained in *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir.1998), "[w]e presume that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." Because Kobs has not presented any specific evidence of a conflict of interest and because the Plan contains a grant of discretionary authority that closely tracks the "safe

harbor" provision we drafted in *Herzberger v. Standard Ins. Co.*, 205 F.3d 327 (7th Cir.2000), we agree with the district court that reversal is only warranted if the administrator's decision was arbitrary or capricious. Under the arbitrary and capricious standard, we do not ask whether the administrator reached the correct conclusion or even whether it relied on the proper authority. *Cvelbar v. CBI Ill. Inc.*, 106 F.3d 1368, 1379 (7th Cir.1997). Instead, the only question for us is whether the administrator's decision was completely unreasonable. *Manny v. Cent. States, Southeast and Southwest Areas Pension and Health and Welfare Funds*, 388 F.3d 241, 243 (7th Cir.2004).

Kobs argues that UWIC's decision was arbitrary and capricious because his treating physician, Dr. Melby, concluded that he was disabled. This argument is unpersuasive for a number of reasons. First, ERISA does not require plan administrators to accord special deference to the opinions of treating physicians. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834, 123 S.Ct. 1965, 155 L.Ed.2d 1034 (2003) (rejecting Ninth Circuit's decision to import the "treating physician" rule from the Social Security context). Second, Kobs makes no effort to address the medical opinions that undermine Dr. Melby's conclusions and support UWIC's determination. Two orthopedic surgeons rejected Dr. Melby's opinion that Kobs was totally disabled due to "musculoskeletal problems," and concluded that he was not disabled from a musculoskeletal standpoint. It makes little sense to give great deference to Dr. Melby's opinion about Kobs' "musculoskeletal problems" when it is contradicted by two physicians who specialize in musculoskeletal injuries. *Black & Decker*, 538 U.S. at 832, 123 S.Ct. 1965. In light of the opinions of the two specialists, it was neither arbitrary nor capricious for

UWIC to conclude that Kobs' claimed physical impairments did not prevent him from performing the material duties of his sedentary job.

The medical evidence regarding Kobs' asserted cognitive impairments also supported UWIC's denial of long-term disability benefits. Dr. Melby referred Kobs to both Dr. Fischer and Dr. Sullivan for psychological testing. While Dr. Fischer diagnosed Kobs with dementia due to traumatic brain injury and global memory deficits, Dr. Sullivan strongly disagreed, concluding that Kobs was not cognitively disabled or memory impaired. Dr. Sullivan, who was not on UWIC's payroll, was also the first of three medical experts who questioned whether Kobs was sandbagging during the tests:

> [T]here are numerous implausible aspects of his performance . . . . First of all, Mr. Kobs' IQ, as measured here, was found to be 80, that is, just barely within the low average range. This is simply not believable. There is no possible way that a head injury of the severity described by Mr. Kobs could have lowered his IQ to this level. Furthermore, there were findings within the IQ testing that were also highly unlikely. Mr. Kobs obtained a score on Vocabulary, which measures knowledge of vocabulary, that was in the low average range. This seems unusually low for a man who finished two years of Boston College and who used to make speeches and sell cars . . . . Furthermore, knowledge of vocabulary is pretty invulnerable to the effects of a mild head injury . . . . Third, Mr. Kobs got just one item right on Picture Arrangement – the first item. He then failed the next four items. This is a ***highly unusual*** performance, even for people who are mentally retarded. Mr. Kobs, even given how poorly he performed, is clearly not mentally retarded.

Ex. M to Szemborski Aff. (emphasis in original). Psychologist Philip Sarff concurred with Dr. Sullivan's assessment that Kobs was exaggerating his symptoms. Dr. Givens and Francine Blaha, a psychiatrist and nurse, respectively, also agreed that Kobs' complaints about cognitive impairments did not match the objective medical evidence. The foregoing medical opinions provided UWIC with reasonable support for its denial of Kobs' long-term disability application.

Kobs also describes the Plan's short-term disability definition and long-term disability definition as "nearly identical," arguing that the disability finding for short-term benefits should have led to a disability finding for long-term benefits. This argument ignores the plain language of the Plan. A Plan participant is "Totally Disabled" under the Plan and thus entitled to long-term disability if (1) he cannot perform the material duties of his position for 30 months (the elimination period plus the benefit period) *and* (2) he cannot perform any of the material duties of any gainful occupation for which he is reasonably suited *after* those 30 months. In contrast, a Plan participant is entitled to short-term benefits if he is unable to perform the material duties of his position during the short-term benefits period. Thus, the provisions are different because they are premised on different time frames and because a worker that qualifies for short-term benefits may not be entitled to long-term benefits if he possesses the ability to perform the duties of *another* occupation for which he is suited. As a consequence, it was not arbitrary and capricious for UWIC to interpret the Plan in a way that granted Kobs short-term benefits and denied him long-term benefits.

A more fundamental problem with Kobs' arguments is that he fails to account for the deferential standard of review that we apply to UWIC's decision. UWIC gathered and reviewed the pertinent medical information, hired a number of physicians to evaluate Kobs and review his medical files, and made an informed judgment about Kobs' long-term disability application that coincided with the bulk of the medical evidence. When Kobs appealed the initial determination, UWIC accepted additional medical information submitted by Kobs, had another psychologist evaluate Kobs, and hired a nurse to review Kobs' entire file. Given this exhaustive process, UWIC's reasonable conclusions, and the absence of evidence of bad faith or conflict of interest, there is no basis to disturb UWIC's benefits determination.

III. Conclusion

For the reasons stated herein, we AFFIRM the decision of the district court.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ELVIS KOBS,

Plaintiff,

v.

UNITED WISCONSIN INSURANCE COMPANY,

Defendant.

MEMORANDUM AND ORDER
04-C-005-S

(Filed May 28, 2004)

Plaintiff Elvis Kobs commenced this action in Polk County Circuit Court against defendant United Wisconsin Insurance Company seeking benefits allegedly due under a long-term disability policy governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001-1461. Defendant removed pursuant to 28 U.S.C. § 1441(a). The Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e)(1). The matter is presently before the Court on defendant's motion for summary judgment. The following facts are those most favorable to plaintiff.

BACKGROUND

Plaintiff Elvis Kobs was a participant in a long-term disability (LTD) group insurance policy issued by defendant United Wisconsin Insurance Company to plaintiff's former employer Bernard's Northtown, Inc. Bernard's Northtown is a car dealership located in New Richmond, Wisconsin. Plaintiff was employed by Bernard's Northtown as a business manager. This sedentary job required him to

sit eighty percent of the day and stand the other twenty. The job required some light lifting of no more than five pounds.

On January 7, 2002, plaintiff applied for disability benefits after sustaining injuries when he fell from his roof. In June 2002, plaintiff underwent an angioplasty after experiencing chest pain. Defendant paid short-term disability benefits to plaintiff from January 2, 2002 through July 4, 2002. Plaintiff requested LTD benefits after exhausting his short-term benefits.

Defendant retained an orthopedic surgeon and a psychiatrist/neurologist to review plaintiff's file. Defendant denied plaintiff's request for LTD benefits stating that it determined that the medical documentation it received did not support plaintiff's inability to perform the material duties of his regular occupation after July 4, 2002.

Defendant offered to review any additional information that plaintiff wished to furnish in support of his disability claim. Plaintiff requested an appeal and submitted additional medical documentation. Defendant obtained documents from the Wisconsin Department of Workforce Development relating to plaintiff's workers' compensation claims for incidents in 1998 and 1999. Defendant also requested that plaintiff undergo an independent psychological evaluation as permitted under the plan. Defendant then retained a board certified psychiatrist/neurologist to review the additional documentation it had gathered during the appeal process. Finally, a registered nurse performed a complete review of plaintiff's file.

On August 27, 2003, defendant's appeal committee convened to review plaintiff's claim. The committee

included representatives from a number of defendant's departments: the Disability and Life Claims Manager, claims representatives, registered nurses, and the workers Compensation Claims Manager. The committee upheld defendant's decision to deny plaintiff's LTD benefits. On September 4, 2003, defendant sent plaintiff a letter outlining the Committee's decision. Plaintiff's administrative remedies exhausted, he commenced the present action.

The following is a summary of the medical reports in the record considered by defendant in denying plaintiff's claim:

(1) Dr. Neal Melby is plaintiff's primary care physician. He opined on several occasions that plaintiff was disabled both as a result of injury to his back and legs and as a result of cognitive disability including memory loss.

(2) Dr. Thomas Reiser is a doctor at the Midwest Spine institute. He saw and evaluated plaintiff in 1999 for back and arm pain and headaches. In a letter of July 30, 2002, he opined "after reviewing the available information" that plaintiff has "a permanent partial disability of 4% to the body as a whole . . . " under applicable workers compensation law.

(3) Dr. Nolan Segal is an orthopedic surgeon who performed an independent medical evaluation of plaintiff on January 2, 2003. He concluded that there was "no evidence [that plaintiff] would be considered disabled from a musculoskeletal standpoint."

(4) Dr. Richard Silver, an orthopedic surgeon, reviewed plaintiff's medical file at the request of defendant and concluded that plaintiff was "fit for duty at a sedentary light capacity . . . from an orthopedic perspective."

(5) Dr. Mary K Fisher is a psychologist who saw plaintiff on a referral from Dr. Melby to evaluate plaintiff's complaints of memory loss, headaches, and cognitive difficulties. She conducted psychological tests on plaintiff, found him "to suffer from deficits in executive functioning including sequencing, planning, mental organization, and metal [sic] control." She also diagnosed him with "global memory deficits." Her conclusion was that plaintiff "meets the criteria for a DSM-IV diagnosis of dementia due to traumatic brain injury."

(6) Mary Sullivan, Ph.D., L.P., performed a neuropsychological evaluation of plaintiff on August 22, 2002 on a referral from Dr. Melby. After consideration of his medical history and testing results she noted:

> All of this background information suggested that Mr. Kobs might have presented himself in such a way as to confirm his own view of himself as memory-impaired and brain-injured. However, there are numerous implausible aspects of his performance which raise questions about the effort he exerted throughout this evaluation.

She concluded that there was no evidence that plaintiff had sustained a closed head injury and that plaintiff was not "cognitively disabled or memory impaired."

(7) Dr. Reginald Givens is a psychiatrist and neurologist hired by defendant to review plaintiff's file. He concluded "according to objective evidence in the medical records, Mr. Kobs does not have a significant impairment that would impair him from performing essential functions of his employment. There are no specific limitations regarding ability to function relating to Mr. Kobs' impairments."

(8) Philip Sarff, is a psychologist employed by defendant to conduct an independent psychological evaluation of plaintiff and to review his medical records. He conducted an evaluation on March 27, 2003 and concluded that plaintiff's "pattern of deficits is not consistent with degenerative dementia, or dementia due to brain injury. Unfortunately, there is strong evidence that he consciously or unconsciously exaggerated symptoms for this evaluation."

(9) Francine Blaha, R.N. reviewed plaintiff's medical records at defendant's request on August 17, 2003. She recommended: "Based on the objective medical documentation provided for review, the objective data does not even come close to the massive subjective complaints of the claimant. Uphold denial."

MEMORANDUM

Summary judgment is appropriate when, after both parties have the opportunity to submit evidence in support of their respective positions and the Court has reviewed such evidence in the light most favorable to the nonmovant, there remains no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c).

A fact is material only if it might affect the outcome of the suit under the governing law. Disputes over unnecessary or irrelevant facts will not preclude summary judgment. A factual issue is genuine only if the evidence is such that a reasonable factfinder, applying the appropriate evidentiary standard of proof, could return a verdict for the nonmoving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 254 (1986).

Plaintiff seeks long-term disability (LTD) benefits allegedly due under an employee benefit plan governed by ERISA, 29 U.S.C. § 1132(a)(1)(B). The LTD plan provides that "[b]enefits under this policy will be paid only if United Wisconsin Insurance Company decides in its discretion that the Insured is entitled to them." This language gives the administrator discretion to determine plaintiff's eligibility for benefits under the plan. *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331 (7th Cir. 2000). Accordingly, the Court reviews plaintiff's determination under an "arbitrary and capricious" standard of review. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). Under the "arbitrary and capricious" standard it is not the Court's function to decide whether it would have reached the same conclusion or relied on the same authority. *Carr v. Gates Health Care Plan*, 195 F.3d 292, 294 (7th Cir. 1999) (citing *Cvelbar v. CBI Ill. Inc.*, 106 F.3d 1368, 1379 (7th Cir. 1997)). "[T]he administrator's decision will only be overturned if it is 'downright unreasonable.'" *Id.*

The presence of an apparent conflict of interest is a factor to be weighed when deciding whether an administrator's decision was arbitrary and capricious. *O'Reilly v. Hartford Life & Accident Ins. Co.*, 272 F.3d 955, 960 (7th Cir. 2001) (citing *Firestone*, 489 U.S. at 115). Plaintiff argues that heightened scrutiny is warranted in the form of either de novo review or a "sliding scale" approach to "arbitrary and capricious" review, *see Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052-53 (7th Cir. 1987), because defendant acted as both plan administrator and insurer in denying plaintiff's claim. If the first-level decisionmaker has an interest in the outcome, this potential for bias is bound to affect the mind set of the reviewing court." *Perlman v. Swiss Bank Comprehensive*

Disability Protection Plan, 195 F.3d 975, 981 (7th Cir. 1999).

More recently however, the Seventh Circuit has observed that conflict of interest concerns are minimal in the typical insurance context. "Most insurers are well diversified, so that the decision in any one case has no perceptible effect on the bottom line. There is correspondingly slight reason to suspect that they will bend the rules." *Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406, 408-409 (7th Cir. 2004). Further, "it is unsound for the judiciary to automatically impute the plan administrator's position to the person who decides on its behalf." *Perlman*, 195 F.3d at 980-81. "Unless an insurer or plan administrator pays its staff more for denying claims than for granting them, the people who actually implement these systems are impartial." *Leipzig*, 362 F.3d at 409. Accordingly, there is little basis to diverge from the arbitrary and capricious standard of review.

Based on the record before it, the administrators denial was reasonable, amply supported by extensive medical records and not arbitrary and capricious. The medical evidence was in near unanimous support of the conclusion that plaintiff was not disabled as a result of any orthopedic conditions. Based on Plaintiff's brief it appears that he does not pursue a contrary position arguing only that reduced cognitive abilities and dementia rendered him disabled. However, the overwhelming weight of the medical evidence – and particularly the conclusions of Dr. Sullivan who was independent and not hired by defendant – suggested that plaintiff's complaints were exaggerated and that he did not have significant cognitive impairment. Defendant was not obligated to blindly accept the testimony of plaintiff's personal physician and the single

psychological expert who supported his position and ignore the numerous opinions to the contrary. Weighing all of the testimony it was entirely reasonable to conclude that plaintiff had no significant mental impairment and was therefore not disabled within the meaning of the plan.

Plaintiff argues that defendant's decision to deny his claim was arbitrary and capricious because the administrative record does not suggest any material change in plaintiff's medical condition from when he was determined to be "totally disabled" under the short-term disability plan and when he was determined not to be "totally disabled" under nearly identical language in the LTD plan:

> If Mr. Kobs made a miraculous recovery on July 4th 2002 (the day short-term benefits expired) there is nothing in the record indicating so. Absent such a medical finding there is absolutely no support for UWIC's conclusion that Mr. Kobs did not qualify for long terms [sic] benefits the first day he was eligible.

Plaintiff's argument is unpersuasive. Defendant's exercise of its discretion to pay plaintiff short-term disability benefits is not an admission that plaintiff was "totally disabled" within the meaning of the short-term disability policy. Moreover, even if defendant had believed that plaintiff was "totally disabled" under the short-term policy, defendant's thorough review of plaintiff's medical documentation – not a belief that plaintiff had made a "miraculous recovery" – was sufficient to dispel such a belief as to the long-term policy.

Finally, plaintiff argues that the administrative record contains no evidence that the experts who opined that he was not disabled considered the material duties of plaintiff's

occupation when it made that determination. Plaintiff's argument fails on two levels. First, most of the experts concluded that plaintiff lacked any significant cognitive impairment. Accordingly, a non-disabled conclusion would follow regardless of particular knowledge of the job duties. Second, it is apparent from a reading of the record that the experts were well aware generally of the mental abilities required to perform the types of tasks associated with plaintiff's position as a car dealership business manager.

Defendant's denial of plaintiff's claim was reasonable and not arbitrary and capricious. Accordingly,

ORDER

IT IS ORDERED that defendant United Wisconsin Insurance Company's motion for summary judgment is GRANTED.

IT IS FURTHER ORDERED that judgment is entered in favor of defendant against plaintiff Elvis Kobs dismissing plaintiff's complaint and all claims contained therein with prejudice and costs.

Entered this ~~22nd~~ 28th day of May, 2004.

BY THE COURT:

/s/ John C. Shabaz
JOHN C. SHABAZ
District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ELVIS KOBS,

Plaintiff,

v.

UNITED WISCONSIN INSURANCE COMPANY,

Defendant.

ORDER
04-C-005-S

* * *

ORDER

IT IS ORDERED that defendant's motion for protective order is GRANTED; the court being of the opinion that a deposition is not required to determine the administration [sic] record in this matter.

IT IS FURTHER ORDERED that plaintiff's second motion for enlargement of time is PARTIALLY GRANTED.

IT IS FURTHER ORDERED that plaintiff may serve and file not later than noon, May 12, 2004 a response to defendant's motion for summary judgment addressing the concerns he has pursuant to Rule 56, Federal Rules of Civil Procedure.

IT IS FURTHER ORDERED that defendant may serve and file a reply not later than noon, May 21, 2004.

Entered this 5th day of May, 2004.

BY THE COURT:

/s/ John C. Shabaz
JOHN C. SHABAZ
District Judge

United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois 60604

April 26, 2005

Before

Hon. Joel M. Flaum, *Chief Judge*

Hon. William J. Bauer, *Circuit Judge*

Hon. Michael S. Kanne, *Circuit Judge*

No. 04-2483

Elvis Kobs,
Plaintiff-Appellant,

v.

United Wisconsin Insurance Company,
Defendant-Appellee.

Appeal from the United States District Court for the Western District of Wisconsin.

Case No. 04 C 5

John C. Shabaz, *Judge.*

ORDER

On consideration of the petition for rehearing and petition for rehearing *en banc*, both filed on March 30, 2005 by the plaintiff-appellant in the above-captioned case, no judge in active service has requested a vote on the petition for rehearing *en banc* and all of the judges on the original panel have voted to deny rehearing. It is, therefore, ordered that rehearing and rehearing *en banc* are DENIED.

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals

DECISION

IN THE CASE OF	**CLAIM FOR**
	Period of Disability, Disability Insurance Benefits, and
Elvis K. Kobs	Supplemental Security Income
(Claimant)	
	387-50-4896
(Wage Earner)	(Social Security Number)

PROCEDURAL HISTORY

The claimant, Elvis Kobs, protectively filed the current applications for disability insurance benefits and supplemental security income on May 29, 2002, alleging disability as of January 3, 2002. His claims were denied initially and upon reconsideration, and a request for hearing was timely filed on December 15, 2003. A hearing was subsequently held on December 15, 2004 in Eau Claire, Wisconsin. The claimant appeared and testified, and was represented by Jason Whitley, an Attorney-at-Law. Donna Kobs, the claimant's wife, appeared and testified on his behalf. Michael Lace, Psy.D., appeared and testified as the neutral medical expert. Sidney Bauer, M.S., the neutral vocational expert, appeared but was not called upon to testify. The undersigned has considered the evidence of record before her and all arguments presented.

ISSUES

The general issue presented by the claims is whether the claimant is entitled to a period of disability and disability

insurance benefits under sections 216(i) and 223, respectively, of the Social Security Act; and whether the claimant is disabled under section 1614(a)(3)(A) of the Act. The specific issues are whether the claimant is under a disability as defined by the Act, and, if so, when such disability commenced and the duration thereof; and whether the disability insured status requirements of the Act are met for the purpose of entitlement to a period of disability and disability insurance benefits.

EVALUATION OF THE EVIDENCE

After carefully considering all of the evidence and testimony of record, the undersigned concludes that the claimant may be found to be under a statutory disability since January 3, 2002, the date he asserted he became disabled, based on his mental impairments, in combination, medically equaling the requirements of sections 12.02, organic mental disorder, 12.04, affective disorder, and 12.07, somatoform disorder, of the Listing of Impairments.

The claimant met the insured status requirements for entitlement to Title II benefits on January 3, 2002, the disability onset date, and continues to meet those requirements through the date of this decision. (Exhibit 4D)

The claimant has not engaged in substantial gainful activity since April 2, 2002, the disability onset date. The record and testimony at hearing indicate that the claimant attempted to resume work after April 2, 2002. He reported that about mid-2003, he went to work as a mortgage loan officer for a mortgage company in New Richmond. He was asked to resign from the position after three months because of poor organization and his need to re-ask a lot of questions. There is no indication in the record that this

activity resulted in earnings at a level considered presumptive of substantial gainful activity. 20 C.F.R. §404.1574(b) and §416.974(b). Thus, the claimant's applications for benefits may not be denied because of substantial gainful activity. (Exhibits 4D, 8E and 2E) The record reveals that the claimant has at least one severe impairment.

The evidence of record establishes that the claimant is subject to mental impairments under section 12.02, organic mental disorder, section 12.04, affective disorder, and section 12.07, somatoform disorder. Thus, the regulations require the undersigned to conduct the sequential evaluation within the provisions of 20 C.F.R. §404.1520a and §416.920a, which include additional analysis and evaluation as amended on September 20, 2000.

The undersigned finds that the claimant is severely impaired by an adjustment disorder with depression and anxiety features, an organic mental disorder secondary to a trauma, and a conversion disorder.

At the hearing, Michael Lace, Psy.D., the neutral medical expert, who specializes in Clinical Psychology, testified that the claimant's mental impairments, in combination, medically equal the requirements of sections 12.02, 12.04, and 12.07 of the Listing of Impairments. Dr. Lace related that the record shows that the claimant struggles with an affective disorder, a depression disorder, not otherwise specified, and diminished mental capabilities due to a head injury. Dr. Lace indicated that the claimant tends to turn stress into physical symptoms, and he has no insights into his problems. The undersigned concurs with Dr. Lace's assessment of the claimant's mental functioning because it is fully supported by the evidence of record. The undersigned finds that the claimant's combination of

ments of section 12.02, 12.04 and 12.07 of the Listing of Impairments as of January 3, 2002. The undersigned further finds that these mental impairments, in combination, has [sic] resulted in mild restriction of activities of daily living, marked difficulties in maintaining social functioning, marked difficulties in maintaining concentration, persistence, or pace, and no episodes of decompensation.

The claimant credibility [sic] testified that he is married and living with his wife. He does the dishes and some cooking, and vacuums on occasion. The claimant indicated that he used to fish and hunt, but no longer engages in these hobbies. He has no social life except for visits with his children and grand children. The claimant stated that he has a driver's license, but only drives once or twice a week. He only drives to grocery stores and physician appointments, but at times, would get confused while driving. The claimant related he was asked to resign from his job as a mortgage loan officer because of poor organization and his need to re-ask a lot of questions. He has problems concentrating, and he forgets what he reads. The claimant stated that he used to do the book keeping [sic] and handle the finances; however, he could no longer perform these duties because he would "goof" everything up. Thus, his wife is now responsible for them. The claimant reported that he is depressed and needs to take medication once a day.

Mrs. Kobs testified that her husband has a poor memory. Her husband would lock his keys in the car, get lost, and forget what he has been told after one hour. Mrs. Kobs related that one time her husband went to the pharmacy and did not remember how to get home. When her husband goes for a walk, he has to be watched; thus, someone is always with her husband. Mrs. Kobs stated that her

husband believes that he is right but is always wrong. He [sic] husband started their new home on fire once when he forgot that he was making an egg sandwich and went to sleep.

A discharge summary dated January 11, 2002, revealed that the claimant was hospitalized for 7 days for falling off the roof of his house. On April 12, 2002, the claimant presented for a neurological consultation of his short-term memory loss. He reported his memory was poor, and he could not remember common things that happened throughout the day and week. He related that a few years ago, he hit his head on a metal cabinet while at work, and he has been treated for depression for five years since his wife was diagnosed with cancer. The claimant indicated that he was taking Paxil. John Floberg, M.D., the evaluating neurologist, stated that the claimant's exam showed some impairment on mental status testing especially for short term memory. Dr. Floberg's assessments were of short-term memory loss, minor closed head injury, and depression. (Exhibits 5F and 7F)

A neuropsychological evaluation on August 22, 2002 by Mary Sullivan, Ph.D., L.P., a licensed psychologist, revealed that the claimant's test results were not consistent with the presence of memory problems secondary to a closed head injury. Dr. Sullivan indicated that although an absence of progressive memory loss should be good news, it probably would not be greeted with much enthusiasm. There was evidence of a tendency to convert stress reactions to physical symptoms, and to be unaware of underlying psychological conflicts or concerns. Dr. Sullivan related that the claimant was experiencing more psychological distress than he was willing to acknowledge. With regard to his ability to return to work, Dr. Sullivan stated that

the claimant had some psychological disturbance which would render it difficult for him to be a fully engaged worker. The claimant saw himself as too sick to work, and he was sincerely convinced of this view, which had been reinforced by his family. (Exhibit 12F)

On November 22, 2002, MaryKay Fisher, Psy.D., evaluated the claimant's cognitive and memory functioning, at the request of his primary care physician. Dr. Fisher stated that the claimant complained of short-term memory impairment, difficulty with comprehension of new material, concentration deficits, sad/worried mood, irritability, decreased frustration tolerance, cognitive slowing, trouble with planning/sequencing/organization, poor mental control, and constant headaches. Dr. Fisher reported that on mental status examination, the claimant was very talkative, and he had a tendency to confabulate, which appeared to be a defensive response to his inability to access memories or information. The claimant was very invested in doing well on the testing, despite it [sic] stated purpose being to document deficits. Dr. Fisher wrote that the claimant's mood was sad and worried, and his affect was dysthymic and of mild intensity and constricted range. His interpersonal good cheer appeared rather forced, and he acknowledged excessive worry, tension, and irritability. Dr. Fisher related that the claimant's sleep and appetite were impaired, and he had difficulty concentrating. He could not watch a television show through to the end, or finish a computer game. Dr. Fisher indicated that he read very slowly, forgetting what he read, and had difficulty with comprehension. His cognitive processing appeared slow. Dr. Fisher related that his narrative stream was halting, and it was apparent that he had retrieval difficulties. His processing was so slow that he

would occasionally lose track of the task, and he had to work very hard to accomplish a mental task and the effort involved was exhausting. Dr. Fisher stated that attention/concentration per se was not the deficiency, rather mental stamina, speed, and control were the areas of greatest impairment. Dr. Fisher concluded that the claimant had dementia due to a head trauma, an adjustment disorder with depression and anxiety, and a head injury. In an accompany functional capacities evaluation/mental abilities and aptitudes form, Dr. Fisher rated the claimant as "limited ability or unable to perform" in most areas under the heading of Understanding, Carrying Out, and Remembering Instruction given at the start of an 8-hour day, during the course of the day; in all areas under the heading of Use of Judgment; and in the area of ability to respond appropriately to changes in a routine work setting under the heading of Dealing with Changes in Routine Work Setting. (Exhibit 14F)

On December 5, 2002, Neal Melby, M.D., the claimant's primary care physician, stated that the claimant had developed a memory deficit, and he and his wife were very frightened by these ongoing problems. The claimant had tried to work as a loan counselor and mortgage office [sic], but was unable to intellectually perform the duties of this job. Dr. Melby further stated that the claimant's findings appeared to be progressive and had led to a great deal of anxiety and depression. Dr. Melby was concerned regarding some potential for suicide. Dr. Melby opined that the claimant was disabled and unemployable. (Exhibit 15F)

On March 21, 2003, Dr. Melby opined that the claimant was capable of less than a full range of sedentary exertional work, with low tolerance for frustration; difficulty communicating his needs; difficulty following instructions;

difficulty engaging in complex tasks that required judgment; difficulty with decision making; difficulty following through on agreed actions; difficulty working around other people; difficulty controlling anger appropriately; socially inappropriate responses to situations; inability to work with children; difficulty with reality interpretation; difficulty being in unfamiliar environments; panic attacks; and difficulty with impulse control. (Exhibit 20F)

A psychological report dated November 13, 2003 by Travis Hinze, Ph.D., a licensed psychologist, at the request of the Social Security Administration, revealed that the claimant's overall current level of intellectual function was in the low average range. Dr. Hinze's impression was of depressive disorder, not otherwise specified, by history. Dr. Hinze stated that based on his evaluation, he was unable to determine the claimant's capability for work capacity or ability to manage funds. (Exhibit 16F)

A review of the overall evidence leads the undersigned to conclude that there are at least two ratings at the degree of severity that satisfies the requirements of the Listing of Impairments. As noted above, Dr. Lace, the neutral medical expert, is also of the opinion that the claimant's mental impairments, in combination, have reached the degree of severity, which satisfied the requirements of sections 12.02, 12.04, and 12.07 of the Listing of Impairments. Accordingly, the undersigned finds that the claimant's mental impairments, in combination, have medically equaled the requirements of sections 12.02, 12.04, and 12.07 of the Listing of Impairment since January 3, 2002. Although there are indications in the record of severe physical impairments, the undersigned finds that further analysis of these conditions is unnecessary since the

claimant has already been found disabled on the basis of his combination of mental impairments.

The undersigned has considered the opinions and assessments rendered by Disability Determination Services' examining and consulting physicians in accordance with Social Security Ruling 96-6p. The undersigned declined to adopt these opinions and assessments in light of the significant new evidence received since those opinions were rendered. Greater weight is given to the opinions and assessments of Dr. Melby, the claimant's treating physician, Dr. Fisher and Dr. Sullivan, consultative psychologists, and Dr. Lace, the neutral medical expert, on the issue of the claimant's mental functioning because of the opportunity they had to review current treatment records. As a result, the claimant is determined to be disabled at all time since January 3, 2002.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. The claimant met the insured status requirements for entitlement to Title II benefits at all times relevant herein.

2. The claimant has not engaged in substantial gainful activity since January 3, 2002, the disability onset date.

3. The claimant is severely impaired by an adjustment disorder with depression and anxiety features, an organic mental disorder secondary to a trauma, and a conversion disorder.

4. The medical evidence establishes that the claimant's mental impairments, in combination, medically equaled the requirements of sections 12.02, 12.04, and 12.07 of the Listing of Impairments, Part 404, Subpart P, Appendix 1.

5. The claimant has been under a disability, as defined in the Social Security Act, since January 3, 2002. 20 C.F.R. §404.1520(f) and §416.920(f).

DECISION

It is the decision of the Administrative Law Judge that, based on the applications protectively filed on May 29, 2002, the claimant has been disabled since January 3, 2002 under sections 216(i) and 223(a), respectively, of the Social Security Act, and sections 1602 and 1614(a)(3)(A), respectively, of the Act.

The component of the Social Security Administration responsible for authorizing supplemental security income payments will advise the claimant regarding the nondisability requirements of these payments, and if eligible, the amount and month(s) for which payment will be made.

/s/ Paul D. Tierney
Paul D. Tierney
Administrative Law Judge

APR 21 2005
Date

LONG TERM DISABILITY
GROUP INSURANCE POLICY

POLICYHOLDER: Bernard's Northtown, Inc.

POLICY NUMBER: 0702273 0000

POLICY EFFECTIVE DATE IS 12:01 A.M.: July 15, 2001

POLICY RENEWAL DATE: August 1, 2002

STATE OF ISSUE: Wisconsin

PREMIUM DUE DATE: 1st day of the coverage month

This group insurance policy is issued to the Policyholder named above, in the state specified, and to the extent that it is governed by state law, the laws of that state will control.

Risk assumed under this policy will be insured from the effective date of this policy, subject to all policy provisions.

The initial term of this policy is the period specified within. However, if this policy is issued as a restatement of the risk assumed by any prior policy issued by United Wisconsin Insurance Company, then, subsequent revision of coverage or premium rate notwithstanding, the initial policy term specified will be deemed to have occurred under that prior policy.

All of the following articles, schedules, and amendments are part of this policy and available benefits are dependent upon them. Altogether this policy is issued on Our authority.

United Wisconsin Insurance Company

_____

President

The Policyholder agrees to all the terms of this policy.

* * *

SECTION I

POLICY OUTLINE

LONG TERM DISABILITY BENEFIT PLAN

BENEFITS:

_____ Class _____

Number	Description	Elimination Period
01	All Actively at Work Full-Time Employees	180 days

Benefit Percentage: 66_% of Pre-Disability Earnings, not to exceed the maximum monthly Benefit. ***NOTE:*** This amount is subject to reductions as specified in Section IV, Benefit Administration.

Maximum Monthly Benefit: $6,000

Minimum Monthly Benefit: The greater of: 1) $100.00; or 2) 10% of the monthly Benefit before deductions for Other Income Benefits. Applies to Total Disability Benefits only.

Maximum Benefit Period: See Section IV, Benefit Administration, Length of Payment.

ELIGIBILITY REQUIREMENTS:

Full Time: 30 hours per week

Service Waiting Period: 90 days; however, eligibility for coverage will be effective on the first of the month coinciding with or following completion of the Service Waiting Period.

Minimum Participation: 10 persons; or
100% of the persons eligible for non-contributory insurance; or

75% of the persons eligible for contributory insurance

PREMIUM RATE: $0.28 per $100 Covered Payroll

INITIAL RATE GUARANTEE PERIOD: 24½ months

CONTRIBUTION: 100% of the premium charges are paid by the Insured.

AMENDMENTS: None

* * *

DEFINITION OF LONG TERM DISABILITY

"TOTAL DISABILITY" and **"TOTALLY DISABLED"** means that due to Injury and/or Illness,:

1. the Insured cannot perform the material duties of his or her regular occupation during the Elimination Period and the following 24 months of the Benefit Period; and

2. after 24 months of the Benefit Period, the Insured cannot perform any of the material duties of any gainful occupation for which he/she is or may be reasonably fitted by education, training or experience.

"PARTIAL DISABILITY" and "PARTIALLY DISABLED" means that due to Injury and/or Illness, the Insured is unable to earn 80% of his or her monthly Indexed Pre-Disability Earnings because of that Injury or Illness and is either:

1. during the first 24 months of the Benefit Period, unable to perform all material duties of his or her regular occupation on a Full-Time basis, but is performing at least one of the material duties

of his or her regular occupation or another occupation on a part-time or Full-Time basis; or

2. after the first 24 months of the Benefit Period, unable to perform the material duties of any occupation for which he or she is or may be reasonably fitted by education, training or experience.

When Totally or Partially Disabled based on objective medical findings, the Insured must be under the Regular Care and Treatment of a Physician and provide documentation of same as required by Us. The Insured may be required to see a Physician selected by Us for an independent medical examination.

* * *

SECTION IV

BENEFIT ADMINISTRATION

BENEFIT DETERMINATION

Benefits under this policy will be paid only if United Wisconsin Insurance Company decides in its discretion that the Insured is entitled to them.

BENEFIT PAYMENT

The Elimination Period must be satisfied while the Insured is Totally Disabled and proof of loss and proof of earnings must be received by Us before Benefits become payable. Refer to the Proof of Loss provision under the General Provisions section of this policy.

If the Insured recovers from a Total Disability during the Elimination Period and returns to Full-Time, Active Work and is Disabled again later, the Elimination Period will be

considered continuous if the work period does not exceed a total of 5 days for every 30 days of the Elimination Period.

Any day the Insured is working between periods of Total Disability will not be counted in the total days required to satisfy the specified Elimination Period. If after a return to Full-Time, Active Work an Insured becomes eligible for or covered under any other group long term disability plan, this paragraph will not apply.

The Insured will qualify for continuing Benefits as long as he/she remains Disabled and requires the Regular Care and Treatment of a Physician. But, We will not pay any longer than the maximum Benefit Period shown in the Policy Outline and the Length of Payment provision.

AMOUNT OF BENEFIT

The monthly Total Disability Benefit will be an amount equal to:

1. a percentage of the Insured's Pre-Disability Earnings up to a maximum Benefit as indicated on the Policy Outline less Other Income Benefits (as defined later in this section); but

2. not less than the minimum Benefit, except in the case of overpayment or while receiving work earnings.

* * *

OTHER INCOME BENEFITS

Other Income Benefits means those benefits for which the Insured is entitled to, whether applied for or not, or receives from any of the sources listed below which will be used to equally reduce the Disability Benefit.

1. The amount for which the Insured is eligible under:
   a. Workers' or Workmen's Compensation Law;
   b. occupational disease law; or
   c. any other act or law of like intent.
2. The amount of any disability income benefits for which the Insured is eligible under:
   a. any other group insurance plan; or
   b. any governmental retirement system.
3. The amount of any disability income benefits for which the Insured is eligible under any compulsory benefit act or law.
4. The amount of disability benefits and/or Retirement Benefits the Insured receives under his or her employer's retirement plan.
5. The amount of employer or Policyholder sponsored salary continuation or sick leave pay.
6. The amount of disability or Retirement Benefits the Insured is eligible for under the United States Social Security Act, or any similar statute of any state or country.
7. The amount of disability or Retirement Benefits the Insured's family is eligible for under the United States Social Security Act, or any similar statute of any state or country.

These Other Income Benefits, except Retirement Benefits, must be payable as a result of the same Disability for which We pay a Benefit.

We may estimate Other Income Benefits and reduce the Disability Benefit if:

1. for Social Security benefits, there is a failure to pursue benefits in a timely manner until denied at the Administrative Law Judge level; and/or

2. for all other benefits listed, it is reasonable to believe that had the Insured applied for the benefit within the required time period, it would have been paid.

After the initial reduction of the monthly Disability Benefit by Other Income Benefits, no additional reduction will be made for subsequent cost of living adjustments to such Other Income Benefit payments.

ADJUSTMENTS AND CHANGES IN BENEFIT

When Disability Benefits are adjusted:

1. whenever Benefit amounts have been underpaid, We will pay the amount necessary to adjust Benefits already paid and adjust current and future Benefits; and

2. whenever Benefit payments have been made in excess of the payment allowed under the policy, the excess payment amount is due and payable to Us by the Insured. We will reduce future Benefit amounts that remain payable if necessary, to recover the overpayment.

Changes in the amount of Benefits payable due to coverage changes will apply:

1. from the effective date of the change; and
2. only to Insureds Actively at Work on or after the effective date of the change; and
3. only after We have approved Evidence of Insurability, if required.

LENGTH OF PAYMENT

The maximum Benefit Period for the Insured Disabled before attainment of age 60 extends until attainment of age 65 subject to the Limitations and Exclusions provision.

The maximum Benefit Period for the Insured Disabled after attainment of age 60 extends until the expiration of the Benefit Period specified in the table below subject to the Limitations and Exclusions provision:

Benefit Duration	
Age at Disability	Benefit Period Limit
61 or younger	To age 65
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

TERMINATION OF BENEFITS

Disability Benefits will cease on the earliest of:

1. the date the Insured is no longer Disabled as defined in this policy; or
2. the date the Insured is no longer under the Regular Care and Treatment of a Physician for the disabling condition; or
3. the date the Insured returns to Full-Time, Active Work unless such work is part of Rehabilitation which has been approved by Us; or
4. the date the Insured dies, unless Survivor Benefits are payable; or
5. the end of the maximum Benefit Period; or
6. the date the Insured's work earnings equal or exceed 80% of his or her Pre-Disability Earnings; or
7. the date the Insured fails to cooperate in Rehabilitation; or
8. the date the Insured fails to submit to an Independent Medical Examination; or
9. the date the Group fails to make reasonable accommodations as defined under the Americans with Disabilities Act.

* * *

NONPARTICIPATING POLICY

This policy is non-participating. It will not receive any distribution from Our surplus earnings, if any; nor will it be assessable to recover loss, if any, to Our equity.

SECTION VII

GENERAL PROVISIONS

ENTIRE CONTRACT AND CHANGES

This policy, including all provisions, schedules, outlines, endorsements and amendments, the application of the Group or Policyholder and the individual applications of the Insureds, and Evidence of insurability, if applicable, constitute the entire contract between the Group or Policyholder and Us. No change in this policy will be valid unless approved in writing by one of Our executive officers and attached to this policy. No agent has authority to change this policy, or to waive any of its provisions.

LEGAL ACTIONS

No action at law or in equity may be brought to recover on this policy prior to the expiration of a 60 day period from the date that written proof of loss has been furnished to Us. No action at law or in equity may be brought after the expiration of a 3 year period commencing from the time proof of loss is required to be provided to Us by the Insured.

Solely at Our discretion, We may elect to use the mediation or binding arbitration procedures of the American Arbitration Association to settle a dispute. Such procedures shall follow the Association's Commercial Rules, and take place in Milwaukee, Wisconsin.

STATEMENTS BY THE GROUP OR INSUREDS

A statement made by the Group or an Insured under this policy will not be used in any legal contest unless a copy of

the instrument containing the statement is or has been furnished to that Group, Insured, or other party to such a contest.

A statement made by the Group or by an Insured will be deemed a representation and not a warranty. A written statement made by the Group or an Insured will not be used as a defense to a claim or to void or reform coverage unless the statement is signed by the Group or Insured, and a copy of the statement is or has been furnished to that Group, or the Insured.

TIME LIMIT ON CERTAIN DEFENSES

Except for fraudulent statements, no statement made by any Insured under this policy relating to that Insured's coverage will be used to contest the validity of the coverage extended to that Insured after the coverage had been in force for a period of 2 years.

NOTICE OF CLAIM

Written notice of claim must be given to Us within 30 days of the Date of Loss or as soon thereafter as it is reasonably possible to give such notice. Notice given by or on behalf of the Insured or their beneficiary to Us at Our home office, P.O. Box 2013, Milwaukee, WI 53201-2013, with sufficient information to identify the Insured, shall constitute notice of claim.

Upon receipt of that notice We will send claim forms to the Insured. If claim forms are not received by the Insured within 15 days of the notice of claim, then the Insured will be in compliance with the requirements of proof of loss when verifiable documentation is received by Us that

establishes the eligibility of the Insured, the date and cause of the Insured's disablement, and the Physician(s) treating the insured for Disability.

PROOF OF LOSS

1. The proof must provide:
   a. the Date of Disability; and
   b. objective medical evidence (the Insured must cooperate in obtaining the medical information); and
   c. dates and type of treatment; and
   d. certification of Total or Partial Disability; and
   e. standard nomenclature diagnosis.
2. Proof of loss must be given to Us within 90 days of the Date of Disability; except, if it is not possible to give proof of loss within 90 days from the Date of Disability, it may be given as soon thereafter as reasonably possible as long as proof of loss is provided within one year and 90 days and We have not been prejudiced by the delay. If We do not receive proof of loss within these required time limits, We will deny the claim. These limits will not apply during periods of Disability or Partial Disability where the insured lacks legal capacity. These time limits will resume once legal capacity is regained.
3. Proof of continued Disability or Partial Disability and Regular Care and Treatment of a Physician must be given to Us within 30 days of the request for the proof. If it is not possible to give proof of continued Disability or Partial Disability

and Regular Care and Treatment of a Physician within 30 days of request, it may be given as soon thereafter as reasonably possible as long as We have not been prejudiced by the delay.

TIMELY PAYMENT OF CLAIMS

Claims incurred while this policy is in force will be paid upon receipt and validation of due written proof of loss. For any loss for which periodic Benefits are payable, We will pay the Benefits at the end of each month, or lesser period, for which We are liable after We receive the required proof. Any balance unpaid when Total or Partial Disability ends will be paid after We receive the required proof.

TO WHOM PAYABLE

Benefits will be paid to the Insured. If any accrued Benefits are payable to either an Insured who is not competent to give a valid release and no guardian or conservator has been appointed by the courts, or to an Eligible Survivor who is a minor or otherwise not competent to give a valid release, We may pay up to a maximum of $1,000 to any one or more surviving relatives We determine are equitably entitled to payment.

If the Insured is deceased and accrued Benefits are payable, We will pay those Benefits to the Eligible Survivor or the Insured's estate.

Any amount We pay in good faith releases Us from further liability for the amount paid.

CLAIM APPEAL

An employee has the right to appeal Our decision regarding any denial of all or any part of a Disability or Partial Disability Claim. The employee must request an appeal within 60 days of receiving Disability or Partial Disability Benefit denial notification.

The request for an appeal must contain the employee's name, identification number and reason for requesting the review. We will review the claim after We receive the request. We will send a notice of Our decision and reasons therefore within 60 days after receiving the request. However, if special circumstances require an extensive review, We will make Our final decision within 120 days of receiving the request.

* * *

CONFORMITY WITH STATE STATUTES

Any provision of this policy that, on its effective date, is in conflict with the statutes of the state in which it is issued, or issued for delivery, is amended by this section to conform to the minimum requirements of that state statute.

SEVERABILITY

Any provision of this policy which may be prohibited by law, will be and will become without force or effect within that jurisdiction; however, the void provision will neither invalidate nor impair the enforceability of any other provision of this policy.

BENEFIT ASSIGNMENT

Benefits under this policy are assignable.

PHYSICAL AND/OR VOCATIONAL EXAMINATION

We may have the Insured examined by a Physician or vocational expert of Our choice when and as often as We may reasonably require. The Insured must cooperate with the examination in order to substantiate proof of loss or continued proof of loss. We will bear the cost of the examination. We reserve the right to withhold or stop Benefits when the Insured fails to submit to a medical exam We schedule.

* * *

[LOGO] United Wisconsin Group

Post Office Box 2013
Milwaukee, Wisconsin 53201-2013
262/787-7400
800/452-4250
Fax 262/787-7575

RAPID PAY INCOME REPLACEMENT PLAN – EMPLOYEE CLAIM FORM

PROMPT SUBMISSION AND COMPLETE INFORMATION ARE NECESSARY FOR THE NON-INTERRUPTION OF YOUR INCOME.

TO BE COMPLETED BY EMPLOYEE

Employee Name	Sex	Date of Birth	Weight	Height	Social Security Number
Elvis Kevin Kobs	M ☒ F ☐	01-25-51			387-50-4896

Mailing Address	City	State	Zip Code	Home Phone
65 County Road M	Star Prairie	WI	54026	715-248-7984

Company Name	Work Address	Work Phone
Bernards Northtown Inc.	510 Deere Dr., New Richmond WI 54017	715-246-2236

Is this disability the result of an accident?	Date	Time	Place
☒ Yes ☐ No	1-4-02	☐ am ☒ pm 12:30	☒ Home ☐ Work ☐

Please describe: Fell off roof while taking down Santa, Sleigh & Reindeer

* * *

EMPLOYMENT STATUS AND SALARY INFORMATION

Employer (Policyholder)	Group/Division No.	Plan Effective Date
Bernards Northtown Inc.	0702273 0000	07/15/01

Group Name	Group Address	City	State	Zip
Bernards Northtown Inc.	510 Deere Drive,	New Richmond	WI	54017

Date of Hire	Effective Date of Coverage	Date Last Worked	How many Hours Worked On Last Day Of Work	Actual Day Returned To Work:
~~7 94~~ ~~03/25/51~~	07/15/01	01/03/02	10 Hours	unknown / /

Employee Status on Last Day Worked
(Give effective date where indicated.)

☑ Active ☐ Personal Leave ☐ Family/Medical Leave
☐ Laid Off ☐ Retired ☐ Terminated
Effective Date: ___ / ___ / ___

Earnings $1637.68
☐ Hourly ☒ Weekly ☐ Bi-weekly ☐ Monthly
☐ Semi-Monthly Earnings Effective Date: 01 / 01 / 01

Benefit Class: ☐ Salaried Exempt ☐ Salaried Non-exempt
☐ Hourly ☐ Union ☐ Other _____

Regular Work Week and Hours Per Day: Mon. 9.0
Tues. 8.0 Wed. 11.0 Thur. 9.0 Fri. ___ Sat. 9.0 Sun. ___

Benefits: Flat weekly benefit amount: $___ OR ___% of salary
Maximum amount: $_____

Percent of premium paid by employer
(based on 3 year average) 6.0%;

Is employee's contribution from pre-tax wages? ☐ Yes ☒ No

Other Benefits:	Sick Pay/ Salary Cont.	$ 0	per week, effective from ___ through ___
	Workers' Compensation	$ 0	per week, effective from ___ through ___
Other (specify)	_____	$ _	per week, effective from ___ through ___

Job Title: Business Manager

Classification: ☒ Sedentary ☐ Light ☐ Medium ☐ Heavy

Physical Requirements of Job: Stands 20% of day; Sits 80% of day; Bends 50 or more times/hour

Lifts 5 lbs. every ?; Carries – lbs. distance ___ frequency ___

Would modified duty be available? ☒ Yes ☐ No

If yes, please indicate type available: _____

---

* * *

[LOGO] United Wisconsin Group

P.O. Box 2013
Milwaukee, WI 53201
262-787-7400/1-800-452-4250
FAX 262-787-7575

October 22, 2002

Elvis Kobs
65 County Road M
Star Prairie WI 54026

RE: Long Term Disability – Bernard's Northtown, Inc.
SS#: 387-50-4896
Group #: 702273/0000

Dear Mr. Kobs:

We received your claim from our Short Term Disability department. We have completed our evaluation of your eligibility for Long Term Disability benefits.

The policy states:

ELIMINATION PERIOD means a series of consecutive days during which benefits are not paid, which begins with the first day of Total Disability and extends for the length of time specified in the Policy Outline (180 days)

"TOTAL DISABILITY" and "TOTALLY DISABLED" means that due to Injury and/or Illness:

1. the Insured cannot perform the material duties of his or her regular occupation during the Elimination Period and the following 24 months of the benefit period; and

2. after 24 months of the benefit period, the Insured cannot perform any of the material duties of any gainful occupation for which

he/she is or may be reasonably fitted by education, training or experience.

"PARTIAL DISABILITY" or "PARTIALLY DISABLED" means that due to Injury and/or Illness, You are unable to earn 80% of Your monthly Indexed Pre-Disability Earnings because of that Injury or Illness and are either:

1. During the first 24 months of the Benefit Period, unable to perform all material duties of his or her regular occupation on a Full-Time basis, but is performing at least one of the material duties of his or her regular occupation or another occupation on a part-time or Full-Time basis; or

2. After the first 24 months of the Benefit Period, unable to perform at least one of the material duties of any occupation for which he or she is or may be reasonably fit education, training, or experience.

When Totally or Partially Disabled based on objective medical findings, the Insured must be under the Regular Care and Treatment of a Physician and provide documentation of same as required by Us. The Insured may be required to see a Physician selected by Us for an independent medical examination."

You became disabled on January 4, 2002. Maximum Short Term Disability benefits were paid to you through July 4, 2002.

We referred your file to an independent medical consulting group. A physician, Board Certified in Neurology and Psychiatry, reviewed the file. Based upon the review, the medical information does not support an inability to perform the duties of your occupation, after July 4, 2002.

We are unable to establish a total disability beyond the policy Elimination Period. Therefore, your claim for Long Term Disability benefits has been denied.

We regret our decision was not more favorable. The decision in this matter has been based solely upon the information contained in our file. As such, we are willing to review any additional material you wish to submit which may have an effect upon the consideration given to this claim.

We reserve all of our rights and defenses, either expressly stated or implied.

If you believe that benefits for your claim have not been administered according to the terms of the contract or your group benefit plan, you have the right to request a review of that claim. You may request this review by writing to:

United Wisconsin Insurance Company
P.O. Box 1167
Milwaukee WI 53201-1167

Your review for a request should be made within 180 days of the date of this letter and should include your name, identification and group numbers, the group name, the date your claim commenced and the reasons you believe the claim should be paid. You may ask us to review specific documents regarding your claim, and you may submit additional records, such as doctor statements for our consideration. You should also include copies of all correspondence you have received from us about your claim. We will inform you of our decision in writing within 45 days of receipt. If special circumstances require that we need more time to consider your review, you will be notified.

If you have any questions, please call this office at 1-800-452-4250.

Sincerely,

/s/ Constance Du Bose
Constance Du Bose
Claim Specialist
United Wisconsin Group

cc: Bernard's Northtown, Inc.

[LOGO] **New Richmond Clinic**

A DIVISION OF
WESTERN WISCONSIN MEDICAL ASSOCIATES S.C.

May 6, 2002

RE: Elvis Kevin Kobs
DOB: 01-25-51

To Whom It May Concern:

This patient was severely injured in a fall in January of this last year. Since then, he has been full disabled and continues to be totally disabled. The patient has severe pain in his left hip which is felt to be a referral pain from his back. He also has a fractured thumb. He did have a head injury with that fall and is in the process of being worked up for memory loss. At this point, it is felt that the patient is unemployable.

Sincerely,

/s/ Neal A. Melby
Neal A. Melby, M.D.

NAM/hkl

[LOGO] **New Richmond Clinic**

A DIVISION OF
WESTERN WISCONSIN MEDICAL ASSOCIATES S.C.

September 19, 2002

RE: Kevin Kobs
DOB: 01/25/51

Constance Du Bose
Claim Specialist
United Wisconsin Group

Dear Mrs. Du Bose,

This patient continues to be totally disabled related in part to injuries that the patient had when he fell off the roof of his house in January of 2002. The patient has injured his lower back, his knees and his left thumb. He also has reported, since that injury, increasing problems with memory loss and has cognitive impairment with his inability to do simple calculations or to remember telephone numbers including even his home phone number. The patient has had a series of workups by different specialists including back orthopedic specialists, general orthopedic specialists, neurologist specialists, psychologists and cardiology specialists as well as physical therapists. The patient's problems include a history of head injury with memory impairment and the impairment of cognitive abilities. He has degenerative disc disease of his cervical spine with chronic mechanical pain. He has multiple level degenerative disc disease of the lumbar spine with circumferential disc bulging and desiccation changes involving L3, L4 an L5 and S1. With the patient's fall from his roof, he has injured his knees and has an internal derangement of the left knee. He has also

fractured his left thumb, which has left him with residual pain and restriction of motion and loss of strength. The patient also has had chest pain and has been evaluated by a cardiology group at St. Paul Heart and Lung. He has an abnormal EKG but has not had any evidence of myocardial infarction and angiograms have revealed no significant blockage of his coronary vessels. He also has known elevated lipid levels and is under treatment for hyperlipidemia and hyperscholesterolemia. In addition, he has a long-standing hx of gastroesophageal reflux and over the last several months has become severely depressed over his lack of progress getting back to a functional status that would allow him to become employable. To date, the patient is continuing to receive therapy and is continuing to be evaluated and most recently has been at the University of Minnesota being evaluated by a psychologist specialist and is undergoing neuro psychometric testing.

In addition, he has daily severe headaches and has chronic swelling of his left lower extremity. The patient has had brain scans, which do reveal some changes within the brain substance in the area of the right frontal lobe, which shows some changes in the subcortical white matter, which may be part of the basis for his memory loss. The patient does have a remote history of head injury. For all the above listed reasons, this patient is considered to be unemployable at this time and is in need of his disability checks for his being able to pay for his number of medications related to attempting to make him comfortable and also to provide some money for his needs for basic daily living. If additional information is requested, please do not hesitate to call us at your convenience.

Sincerely,

/s/ Neal A. Melby, M.D.
Neal A. Melby, M.D.

NAM/anm

[LOGO] **New Richmond Clinic**

A DIVISION OF
WESTERN WISCONSIN MEDICAL ASSOCIATES S.C.

December 05, 2002

Mr. David Erspamer
Attorney At Law
FAX: (715) 268-7890

RE: Mr. Kevin Kobs
65 County Road M
Star Prairie, WI 54026

Dear Mr. Erspamer,

I am responding to a letter that you had sent to Mr. Kobs dated October 31, 2002 regarding his injuries resulting in his disability claims. The patient had suffered multiple injuries while employed at the Bernard's Northtown, Inc. Mr. Kobs has documented the dates of his injuries and his resultant complaints which are leading to his problems with his musculoskeletal system as well as with his central nervous system and more specifically his memory loss. The patient has undergone a second neuro psych testing and was most recently evaluated by Mary K. Fisher, Psy.D, who performed various psychological tests which have lead to several conclusions with objective abnormalities noted on psychological testings performed leading to the diagnoses as listed in her reports. I believe that Mr. Kobs is disabled and that he is disabled as a result of his injuries starting with the injuries to his back as well as to his head. He has objective evidence showing that there has been definite change from the MRI dated July of 1997 which shows the patient having an essentially negative MRI evaluation of his brain without intracranial abnormalities noted, compared to an MRI of his

brain dated 3/8/02, which definitely showed a nonspecific focus within the white matter of the right frontal lobe. In addition, the patient's lumbar spine x-rays in September of 1999 did show some mild disc space narrowing at L5 and S1 with some mild facet arthritis or facet arthropathy. A subsequent MRI of his spine did show degenerative spondylosis in L3, L4 and L4, L5 and L5, S1 with said anthropathy to L5 and S1. Subsequent MRI in April of 2002 did show disc narrowing, desiccation change and circumferential disc bulging with facet and ligamentum flavum hypertrophic changes at the levels of L3-4, L4-5 showing mild central canal stenosis and a small posterior central disc herniation at L5 and S1. These are all new changes compared to the previous MRI. It is my opinion that the patient's fall did aggravate the pre-existing condition and has led to further degenerative changes in the patient's spine. I think there is definitely a correlation between the patient's work-related injuries and his current symptoms.

With the patient's fall from his roof in January of 2002 the patient had injured his musculoskeletal system including his left shoulder area with separation of the AC joint. The patient also injured his neck leading to pain in his neck. MRI of the C-spine did show degenerative disc changes with bulging of the anulus [sic], which did appear to touch the anterior aspect of his cord but without cord deformity. This did not appear to cause any cord deformity or neural involvement. An x-ray of the patient's left hand did show a fracture of the base of his 1st metacarpal on the left. An MRI of his knee did show a posterior medial meniscus tear and joint effusion. All of these findings are consistent with injuries dating to this patient's ongoing disability.

In summary, Mr. Kobs has developed musculoskeletal problems that are leading to his inability to work. In addition, he has developed a memory deficit, which the psychologist has listed as dementia. The etiology of that is not exactly apparent to me at this time. We are recommending that the patient have further extensive neurological evaluation and recommend the Mayo Clinic for their expertise in trying to establish the etiology of this and the progression. The patient and his wife are very frightened by these ongoing problems. Mr. Kobs has tried to work as a loan counselor and mortgage officer, however he is unable to intellectually perform the duties of this job. His findings appear to be progressive and have lead to a great deal of anxiety, depression and my concern regarding some potential for suicide. These obviously are all very concerning symptoms and findings and this patient definitely is disabled from all of the above listed problems and is unemployable.

I hope this information is of use to you in attempting to being able to understand this patient's problem and disabilities. We are enclosing copies of the significant x-ray reports to further substantiate our findings.

Sincerely,

/s/ Neal A. Melby, M.D.
Neal A. Melby, M.D.

NAM/anm

Enclosure

[LOGO] **New Richmond Clinic**

A DIVISION OF
WESTERN WISCONSIN MEDICAL ASSOCIATES S.C.

April 21, 2003

RE: E. Kevin Kobs
Date of Birth: 1-25-51

To Whom It May Concern:

Both Mr. and Mrs. Kobs are chronically disabled and are unable to pursue gainful employment. They both have rather significant medical conditions which do require transportation to their treating facilities, that is clinics and hospitals, on a regular basis. At times, their medical problems do involve emergencies which require a rapid transport to the hospital, and again are in need of means of personal transportation. Because of the HIPPA regulations, I am unable to give you specific information about their medical conditions. This information will need to come from both Mr. and Mrs. Kobs directly.

Sincerely,

/s/ Neal A. Melby, M.D.
Neal A. Melby, M.D.

NAM/mas

MARY KAY FISHER, PSY.D.
THE SANCTUARY FOR WOMEN AND GIRLS
715 ORANGE ST.
HUDSON, WI 54016
(715) 386-1634

November 27, 2002

Elvis Kevin Kobs
65 County Rd. M
Star prairie, WI 54026

Dear Mr. Kobs:

Enclosed are 3 copies of my report detailing the results of psychological testing performed on November 22, 2002.

Because I neglected to have you sign an authorization to release the information directly to your physician. I am sending all copies to you, and will leave it to you to distribute them in whatever way you deem appropriate.

Thank you for the opportunity to work with you. I wish you the best of luck in your future endeavors.

Sincerely,

/s/ Mary Kay Fisher, Psy.D.
Mary Kay Fisher, Psy.D.
WI Lic. #2325-057

ELVIS KEVIN KOBS **D.O.B. 1/25/01** [sic]
November 27, 2002 **Test Date: 11/22/02**

INTRODUCTION

Elvis K. Kobs is a 51-year old male who was referred by his physician, Dr Neal Melby, for evaluation of cognitive and memory functioning, subsequent to a work-related

accident on 1/4/02. A mental status exam, Wechsler Memory Scale (WMS-III), and Wechsler Adult Intelligence Scale (WAIS-III) were administered.

CHIEF COMPLAINT

Mr. Kobs complains of short-term memory impairment, difficulty with comprehension of new material, concentration deficits, sad/worried mood, irritability, decreased frustration tolerance, cognitive slowing, trouble with planning/sequencing/organization, poor mental control, and constant headaches. Brain imaging revealed a white mass in "left central lobe," according to the patient; however, a physician told him that that finding "wasn't related to memory centers."

HISTORY

Mr. Kobs was a financial manager for 21 years. He always had a good head for numbers, and a good memory for facts and figures. Within the past 3 years, his wife was diagnosed with cancer. She has received treatment, and the cancer is currently in remission. She also suffers from lupus, diabetes, and mytral valve prolapse.

In 1998 or '99, Mr. Kobs hit his head on a steel cabinet at work. He experienced memory impairment after this injury. Since then, he has used note and other mnemonic strategies to get by. He sustained another work-related injury on January 4, 2002, this time falling 35 feet and landing on a concrete floor. Since then, cognitive deficits have increased substantially. The following medications are prescribed:

- Effexor
- Oxycontin
- Celebrex
- Lipitor
- Prevacid

Alcohol and Substance Abuse History: Mr. Kobs underwent counseling for a drinking problem several years ago. He denies current alcohol use. He has never used illegal drugs.

MENTAL STATUS

General Appearance: Elvis Kevin Kobs presented as a personable middle-aged gentleman with a ready handshake and an engaging interpersonal manner. Height was perhaps a little taller than average; he was a little overweight. Gait and station were unremarkable.

Attitude and Behavior: Mr. Kobs was open and direct concerning his condition, and his fears about its long-term implications. He tended to be very talkative. There was a tendency to confabulate, which seemed to be a defensive response to his inability to access memories or information. He seemed very invested in doing well on the testing, despite its stated purpose being to document deficits. It appeared that he would much rather find out that he was intact and healthy. His approach to testing was conscientious, his application steady. Results are judged to be reliable estimates of current functioning.

Mood and Affect: Mood was sad and worried; affect was dysthymic, of mild intensity and constricted range. Interpersonal good cheer seemed rather forced. He acknowledged excessive worry, tension, and irritability.

Vegetative Signs: Sleep and appetite are both impaired. There is difficulty concentrating; he cannot watch a TV show through to the end, or finish a computer game. He reads very slowly, forgetting what he read, and has difficulty with comprehension. No psychomotor abnormalities were observed; however, cognitive processing appeared slowed.

Thought Process and Content: Narrative stream was halting; retrieval difficulties were apparent. Speech was logical and goal-directed. No signs of formal thought

disorder were reported or observed. Suicidal and homicidal thinking were denied.

Attention and Concentration: Mr. Kobs was capable of a steady application of effort. However, processing was so slow that he would occasionally lose track of the task. It was also clear that he had to work very hard to accomplish a mental task, and the effort involved was exhausting. It would appear, then, that attention/concentration per se is not the deficiency; rather, mental stamina, speed, and control are the areas of greatest impairment.

Abstraction, Insight, Judgment: Answers to questions designed to tap abstract thinking suggest at least average premorbid intelligence. Judgment appears good. He does not seem to be very introspective by nature; insight is judged to be fair.

Memory (WMS-III Results):

PRIMARY INDEXES	SUM OF SS	INDEX SCORE	95% CONF. INTERVAL	PR	QUALITATIVE DESCRIPTION
Auditory Immediate	16	89	83-97	23	Low Average
Visual Immediate	13	78	72-92	7	Borderline
Immediate Memory	29	80	74-90	9	Low Average
Auditory Delayed	14	83	76-94	13	Low Average
Visual Delayed	11	72	67-87	3	Borderline
Auditory Recog. Del.	7	85	78-100	16	Low Average
General Memory	32	75	69-85	5	Borderline
Working Memory	15	85	78-96	16	Low Average

(Index scores have a mean of 100 and a standard deviation of 15. Obtained scores are assumed to contain error variance. The confidence interval corrects for this by providing a range within which the "true score" is expected to fall.)

Results show an individual whose overall memory functioning falls in the borderline range, at the 5th percentile compared to the standardization sample. Working memory fares slightly better, in the low average range at the 16th percentile. Although a casual glance might suggest that visual memory is more impaired than auditory memory, these differences do not reach statistical significance. Reference to the large overlap between confidence intervals will help explain why this is so.

* * *

SUMMARY

In sum, this gentleman does appear to suffer from deficits in executive functioning, including sequencing, planning, mental organization, and mental control. Cognitive processing is markedly slowed, stamina is weak, and these, in turn, affect concentration. Deficits in working memory are moderate to severe, with deficits increasing as task complexity increases. Remote semantic retrieval is at least mildly impaired – with slowed processing speed exacerbating the retrieval difficulty. Auditory and visual memory, both immediate and delayed, are impaired as well. In short, there are global memory deficits, with the possible exception of autobiographical event memory.

Judging from clinical observation and test results, the conclusion is that this patient meets criteria for a DSM-IV diagnosis of dementia due to traumatic brain injury. In addition, the stress of his wife's illness, financial difficulties, embarrassment and frustration related to his

condition, and uncertainty about his future capacities and options are causing a mood disturbance best conceptualized as an adjustment disorder with depression and anxiety.

DSM-IV DIAGNOSIS

Axis I:	294.1 Dementia due to head trauma 309.28 Adjustment Disorder with Depression and Anxiety
Axis II:	V71.09 None
Axis III:	854.00 Head injury
Axis IV:	Severe: Functional difficulties, wife's illness, financial difficulties
Axis V:	Current GAF: 51

I appreciate the opportunity to be of service. Please let me know if there's anything else I can do.

Respectfully submitted,

/s/ Mary Kay Fisher, Psy.D. 11/27/02

Mary Kay Fisher, Psy.D. Date

WI Lic. #2325-057

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July 30, 2002

David M. Erspamer
Erspamer Law Office
Suite 165
314 Keller Avenue North
Amery, Wisconsin 54001

RE: Elvis (Kevin) K. Kobs
Date of Birth: 01-25-1951
Date of Injury: March/April, 1999; and
June/July, 1999

Dear Mr. Erspamer:

This is in response to your letter of May 24, 2002.

According to Mr. Kobs, it was some time in August 1999/September 1999, he was sitting at his desk and bent over to open a low drawer. He felt immediate low back pain. He saw Dr. Melby and had x-rays and received medication. At the end of September 1999, he ran into a steel cabinet at work and had a bruise on his head. He was seen in the emergency room for neck pain, nausea, and headaches.

I initially saw him December 29, 1999 for complaints of constant neck pain and headaches. He also had constant upper back pain and intermittent arm pain to the elbow with numbness and tingling in his hands. He had constant low back pain with right leg pain to the calf. On cervical examination, he had a positive Adson's on the right and a positive Tinel's at the right elbow along with positive Tinel's at both wrists. He had a history of polio and could not walk on his heels because of that. He had pain over the left SI joint to palpation. Strength of the anterior tib and EHL bilaterally was 4/5 from his prior polio. Cervical x-rays showed mild calcification of the ligament anteriorly at C6-7 but otherwise were normal. Lumbar x-rays were normal. Lumbar MRI from December 17, 1999 showed degenerative changes within the annulus at L3-4 with dehydration and bulging at L4-5 and L5-S1. I recommended physical therapy, Anaprox, and a cervical MRI scan.

A cervical MRI scan completed January 4, 2000 showed a small disc herniation at C5-6 and degeneration at C3-4. He was still having headaches at his February 11, 2000 office visit, but I felt that the changes on the MRI scan were not necessarily related to his complaints. I recommended that he follow-up with neurology.

I did not see Mr. Kobs again until May, 25, 2002. He reported falling thirty-five feet onto concrete. He apparently was hospitalized on January 3, 2002 at New Richmond Hospital. He fractured his hand and injured his left knee and left leg. I saw him for complaints of pain in the neck, midback, low back, and left leg. On examination that day, he had general pain to palpation throughout the spine. Flexion of the lumbar spine brought his fingertips to eight inches from the floor. Motor and sensory examinations

were normal in both upper and lower extremities. Cervical spine MRI scan from March 8, 2002 showed mild degenerative disc disease which I felt was not significantly related to his ongoing problem. Lumbar MRI scan from April 30, 2002 demonstrated degenerative disc disease at L3-4 and L4-5 with mild stenosis at both levels. There was a small central herniation at L5-S1 of questionable clinical significance. I ordered a thoracic MRI which was done May 21, 2002. That scan showed mild degenerative changes in the mid and lower thoracic spine without compression fractures or herniations.

Mr. Kobs' past medical history, to my knowledge, included an incident when he slipped at work in December 1998 and had immediate neck and low back pain. He apparently saw Dr. Melby for three or four months and had a complete recovery and had no further treatment until the incident in August/September 1999 when he bent over.

It is my opinion, after reviewing the available information, that Mr. Kobs has a permanent partial disability of 4% to the body as a whole for his cervical condition based on Wisconsin Worker's Compensation Statutes. I feel that 50% of his current cervical condition is due to the September 1999 incident when he hit his head, and 50% of his cervical condition is due to the prior fall on the ice at work in December 1998. With regards to his lumbar condition, I feel he has a 4% permanent partial disability to the body as a whole based on Wisconsin Worker's Compensation Statutes. Fifty percent of his current lumbar condition is due to the August/September 1999 bending incident and 50% is due to the prior fall on the ice in December 1998. The fall in January 2002 was a significant aggravation to a preexisting degenerative condition. I have recommended continued conservative treatment including epidural

steroid injections in the cervical and lumbar spine. He does not require surgery. He should follow-up with Dr. Melby, and I would be happy to see him as-needed.

If you have further questions, feel free to contact my office.

Sincerely,

/s/ Thomas Rieser
Thomas V. Rieser, M.D.

TVR//kms

MEI

MEDICAL EVALUATIONS INC.

January 30, 2003

Ms. Cynthia K. Thurston
McCollum, Crowley, Vehanen,
Moschet & Miller, Ltd.
1801 West Knapp Street, Suite 6
Rice Lake, WI 54868

RE: Elvis Kevin Kobs
Your File Number: 10587 54W
MEI Invoice Number: 37301

Dear Ms. Thurston:

I had the opportunity to evaluate Mr. Elvis Kevin Kobs in St. Paul, Minnesota, on January 2, 2003, for the purpose of an Independent Medical Evaluation.

HISTORY

Mr. Kobs is a 51-year-old male who is noted to be a somewhat poor and vague historian. He states that he started employment for Bernards Northtown as a Senior Finance and Lease Manager beginning either in 1992 or 1994. Prior to that, he worked for 13 years as a business manager for a company on the east coast.

* * *

He states that he has been out of work since early January 2002. He states that after he hit his head, he could not remember things. He states that only he knew about it. He states that he took a lot of notes and kept messages so he could continue to keep going without anyone else really knowing. He states that now it is at the point where it is hard to remember things and he is very upset about it. He

thought it would get better with time, but it has not. He states that he has had tests on everything and he has seen multiple specialists. He states that with the last test that he had, he was diagnosed with dementia. He has short-term memory loss. He states that all of these are detailed in a report from his primary doctor, Dr. Neal Melby of New Richmond. He states that Dr. Melby saved his wife from cancer.

CURRENT STATUS

Mr. Kobs states that he continues to have symptoms. He has pain in the low back, neck, and shoulders. He has daily headaches and nothing helps. He states that he cannot take ibuprofen because of gastrointestinal problems. He takes Tylenol Arthritis, which helps a little. He states that he has intense frontal headaches that will occasionally cause him to throw up. He states that he has a Jacuzzi at home and he sits in it a lot and this helps some. He states that he has a moist heating pad. He will use this on the base of the neck and it helps his head and neck. He states that his legs swell. He states that both knees hurt. He states that his calves are hard as rocks by the end of the day. He has shooting pain in the low back and buttock areas if he bends over. If he puts his head down in a flexed position, he gets pain from the neck down to the middle of the back. He states that he cannot drive with his hands up or his hands go to sleep. This involves the ulnar three digits of both hands, but sometimes his entire arm is dead from the elbow down. He states that he has had three cortisone injections into his back and these have not helped. He states that it is aggravating, frustrating, and "stupid."

He has symptoms on a daily basis. He notices that for the first three to four hours in the morning his symptoms are unbearable. It takes him three to four hours to get on an even keel before he can do anything. It hurts to stand in the mornings. He sits in the shower and takes a shower as hot as he can tolerate and then he sits in a Jacuzzi for one-half hour. He then loosens up. He states that he is in pain the rest of the day. He does get a little bit better, but then his legs swell. His back pain, however, does not get better, and gets worse as the day goes by. He sits in a recliner with the heat on or will put his legs up in bed with heat.

He does have sleep disturbance due to symptoms. He states that he has gone three days without sleep and this is even with the medications. Any activity will increase symptoms. When reading, his head will pound and he cannot do it. He can only spend a short time on a computer. He states that any activity that he does, he can only do for short periods. Driving is terrible. He states that he had a one hour and 20 minute drive to this appointment. He states that his left leg will bother him and kill him. He states that he gets by with short trips. He lives six miles from town.

He states that from an activity standpoint he has given up everything including bowling, hunting, fishing, and dancing. He can only fish in one spot for an hour. Nothing really helps reduce symptoms. Medications really do not help much.

From a treatment standpoint, he states that he goes in for follow-up visits with his doctors and is on medications. He had physical therapy that would take the edge off for about two to three hours, but, again, nothing really helped. He states that he is not getting any treatment now

because he has no insurance. He states that he was given home exercises that he does. It appears that exercises are rather minimal. He states that he cannot recall what these exercises are without the sheet to review.

He states that he is not getting any better. Today is a bad day in terms of symptoms.

* * *

There are marked inconsistencies in his neuropsychological testing and opinions regarding his cognitive deficits. I find evidence from a musculoskeletal standpoint to suggest symptom magnification and functional overlay, and find evidence to suggest that his subjective complaints are not in fact consistent with objective examination findings or radiologic findings. These same opinions have been alluded to by his treating physicians in the past, including orthopedic surgeons and neurologists. His tendency to somatization of his psychological stressors has been well documented over the years. There is, therefore, no evidence that Mr. Kobs would be considered disabled from gainful employment from a musculoskeletal standpoint. It does appear that he had a significant change in his overall abilities to function on several levels following his home-related fall of January 2002.

If any further information is needed, please feel free to contact me through Medical Evaluations, Inc.

Sincerely,

/s/ Nolan M. Segal, M.D.
Nolan M. Segal, M.D.
Orthopedic Surgeon

NMS/sf

UNIVERSITY OF MINNESOTA

Twin Cities Campus

Mayo Mail Code 295
420 Delaware Street, Southeast
Minneapolis, MN 55455

Office: 612-625-9900
Fax: 612-625-7950
www.neurology.umn.edu

Department of Neurology
Medical School

SUMMARY OF NEUROPSYCHOLOGICAL EVALUATION

Patient's Name:	**KOBS**, Elvis Kevin
Medical Record #:	**0050132702**
Date of Evaluation:	August 22, 2002
Referring Physician:	Neal Melby, M.D. New Richmond Clinic New Richmond, WI

I. REASON FOR REFERRAL

Mr. Kobs, a 51-year-old, right-handed man, was evaluated for documentation of his cognitive baseline in the setting of his complaints about his memory. Mr. Kobs suffered what sounded like a mild closed head injury in 1999, followed by a fall from a roof onto his left side which spared his head this past January. Mr. Kobs, according to office notes from Dr. Melby, began complaining about memory loss after the fall from the roof.

* * *

Regarding the memory loss he reportedly experienced after he hit his head, he reported that at work his general manager kept giving him sly (Mr. Kobs used the word

"slide") comments that he, the manager, could match Mr. Kobs's brain any day. Mr. Kobs reported that he did not understand where his general manager was "coming from," since he has reportedly had twenty-six years of experience as a business manager, and "never, ever made any mistakes in [my] life as far as [my] work." Mr. Kobs reported that subsequent to the incident, he started having to take a lot of notes at work. He reportedly used to deal with twenty or more banking institutions and could remember their fax and phone numbers, but started having to look the numbers up in his computer. He reportedly recently went to town and could not remember his home phone number, so he went to his daughter's to ask her. He commented, "I want to know why this is happening." Mrs. Kobs reported that her husband's short-term memory is getting worse and worse, but his long-term memory is fine. When Mr. Kobs was asked about his ability to pay attention, he denied any problems, but Mrs. Kobs reported that he "almost just doesn't get it." Mrs. Kobs also reported that she has to write out the checks because "he forgets." Mr. Kobs, however, reported that he has cashed in his 401K and brought his first and second mortgages up to date.

* * *

Mr. Kobs might have presented himself in such a way as to confirm his own view of himself as memory-impaired and brain-injured. However, there are numerous implausible aspects of his performance which raise questions about the effort he exerted throughout this evaluation. First of all, Mr. Kobs's IQ, as measured here, was found to be 80, that is, just barely within the low average range. This is simply not believable. There is no possible way that a head injury of the severity described by Mr. Kobs could have lowered

his IQ to this level. Furthermore, there were findings within the IQ testing that were also highly unlikely. Mr. Kobs obtained a score on Vocabulary, which measures knowledge of vocabulary, that was in the low average range. This seems an unusually low score for a man who finished two years of college at Boston College and who used to make speeches and sell cars, a man who reportedly was making an average of $80,000 a year or more and who probably relied on his verbal skills to help him make that kind of money.

* * *

With respect to personality functioning, as discussed above, Mr. Kobs appears to be having a conversion reaction, e.g., he may be converting psychological problems into physical symptoms, without any awareness of his behavior. Thus, the results of the MMPI-2 suggested that these efforts to make himself look cognitively impaired were not done deliberately, e.g., with the intent to deceive. Mr. Kobs's view of himself as physically unwell and cognitively impaired could have skewed his performance unintentionally in the direction of impairment, when in fact these results, when interpreted in light of all the available information, suggest the opposite – that he is not memory disordered or cognitively impaired. In other words, Mr. Kobs seems to have convinced himself that he has memory impairment, with, it would seem, Mrs. Kobs's unwitting reinforcement. It was clear that she perceives him as having deteriorating short-term memory, but did not provide a lot of history to substantiate her view.

* * *

In summary, the results were not consistent with the presence of memory problems secondary to a closed head

injury. There was in fact no real evidence that he had sustained a closed head injury, e.g., an injury that would have produced cognitive effects. Mr. Kobs's performance was thought to be influenced by his conviction that he is ill and his denial of physical and cognitive well-being. Although an absence of progressive memory loss should be good news, it probably will not be greeted with much enthusiasm. There was evidence of a tendency to convert stress reactions to physical symptoms, and to be unaware of underlying psychological conflicts or concerns. Mr. Kobs was thought to be experiencing more psychological distress than he was willing to acknowledge. It was recommended that he receive supportive counseling. A referral to William Robiner, Ph.D., ABPP, L.P. or Diane Bearman, Ph.D., L.P., health psychologists in the Department of Medicine here at Fairview-University Medical Center, is suggested. This referral would be made by Dr. Melby. Dr. Robiner may be reached at (612) 624-1492, and Dr. Bearman at (612) 624-0933.

With regard to the issue of a return to work, Mr. Kobs passed along a variety of disability forms to be completed. It is this examiner's opinion that he is not cognitively disabled or memory impaired. However, he appears to have some psychological disturbance at this point which would render it difficult for him to be a fully engaged worker, e.g., he sees himself as too sick to work and he is sincerely convinced of this view. Further, this view has been reinforced by his family. He has physical injuries and chronic low back pain. It is therefore also recommended that he be referred to Miles Belgrade, M.D., at Fairview-Riverside, for help in dealing with what appears to be a chronic pain syndrome. Dr. Belgrade may be reached at

(612) 273-5400. Again, Dr. Melby would make this referral if he deemed it appropriate.

The opportunity to address questions regarding Mr. Kobs's cognitive status is appreciated. Thank you for the very interesting referral. If there are questions about this evaluation, please do not hesitate to call (612) 625-7423.

/s/ Mary Sullivan, Ph.D., L.P.
Mary Sullivan, Ph.D., L.P.
Assistant Professor of Neurology

[LOGO] GARY L. FISCHLER ASSOCIATES, P.A.

604 Parkside Professional Center
825 South 8th Street
Minneapolis, MN 55404

[Names And Telephone Numbers Omitted In Printing]

PSYCHOLOGICAL EVALUATION

***Client Name*:**	Elvis Kobs
***Date of Evaluation*:**	March 28, 2003
***Referred by*:**	Elite Physicians, Ltd.
***Date of Report*:**	March 30, 2003

* * *

RELEVANT HISTORY (according to the subject): Mr. Kobs reports that he quit high school when he was 16 years old in order to get married, after his girlfriend became pregnant. He later earned his high school diploma through a home schooling program sponsored by a university in Illinois; he claimed he could not recall the name of the university. Prior to quitting school, he says his grades were "immaculate" and all As and Bs. He states that he retook an algebra course because he "didn't pay attention" the first year. He says he "aced it" the second time. Mr. Kobs denies any history of being diagnosed with a learning disability or receiving special education services in school. He also denies any history of behavioral problems in school. While he says he was shy in high school, he also was President of his junior class and was elected to be the Master of Ceremonies for the prom. He says he was a bit of a "geek" in school and seemed to need to work harder to earn good grades than other students. He denies any known history of attention-deficit problems in school. After moving to Boston in 1981, and living there for a period of time, Mr. Kobs attended Boston College for night school for

a couple years, and he suspects her [sic] earned Bs in those classes. Also, while living in Massachusetts, he successfully completed a course to get his real estate license.

The client reports that he was most recently employed at a mortgage finance company, and that lasted about 90 days until the end of 2002. He says he was offered a position by acquaintances he had met while working at the auto dealership. He reports that he had trouble doing the paperwork portion of that job, such as organizing the mortgage application file in the proper sequence. He was eventually encouraged to quit, and he never actually saw a loan to completion. Prior to that, he had been working for Bernard's Northtown, which is a car dealership, and his position was that of Business Manager. He was fired from that job on 5/21/02, when he received a certified letter in the mail. He was upset about that because three weeks prior, he had had a meeting with the owner and the owner commented, "You look like shit", to which the client commented, "I feel like shit." He further states that the owner had stated, "All I want you to do is get better" and he encouraged him to take some time off.

* * *

Mr. Kobs reports that in 1998 or 1999 he fell twice at work. He says he hurt his back the first time he fell. The second time, he struck his head on a steel cabinet that was situated by a door, and he hit his head has [sic] he was poking his head out to say something to someone. He hit his head on the left side (toward his forehead) and fell to his knees. He was not knocked unconscious, but he says he had little memory of what he did the rest of that day. He reports feeling nauseated. He went to the doctor the next day. He reports that he started having headaches after that incident, and had had [sic] never suffered from headaches before. Eventually, he had a CT scan and the

radiologist told him there was "a spot in the center of by [sic] brain" but that the doctor did not have any idea what it was, and tried to reassure that [sic] client that he had nothing to worry about. His regular doctor had agreed to do some more testing, but by that time, the client no longer had insurance coverage.

Mr. Kobs states that he began noticing memory problems from the time he hit his head on the steel cabinet. At work, he says he started to rely on notes to remember things and that he had hoped nobody would find out what was going on. At this point, he says his memory problems are "very sporadic" and that he is liable to forget a number of different things. For example, he says that his daughter had been over to visit the other day with his granddaughter, and he had enjoyed the company of his granddaughter for a while. Later that day, after his daughter and granddaughter had left, he had talked to his son-in-law and had asked the client, "Was your daughter out today?" He told his son-in-law that he had not seen her that day. Then, the client's daughter called him and asked, "Didn't you remember me being there?" He states that he had remembered they were there, but thought it was the day before. Mr. Kobs also reports that he forget [sic] numbers like never before, and that he used to have 100's of phone number and Fax numbers memorized. He says he even forgets his own phone number, or at least turns the numbers around.

Mr. Kobs reports that he feil from his roof, and he estimates that it was 35 feet, and he landed on his left side and suffered several injuries. He does not recall having the falling sensation, but he remembers getting the wind knocked out of him and not being able to breathe. However, he says he was not knocked unconscious. That

occurred January 2002. He says he has had chronic pain since then, and now has "whole body pain."

* * *

DIAGNOSTIC IMPRESSIONS:

Axis I. 1. Depressive disorder, NOS (311.0), with anxious features.

2. History of alcohol abuse (305.0), in remission.

3. Probable Pain disorder associated with both psychological factors and injury (307.89)

2. [sic] R/O Malingering

Axis II. Diagnosis deferred.

Axis III. Possible concussion in 1998 or 1999, by client's report; history of coronary disease; history of back/knee injury, secondary to fall; polio as a child.

Axis IV. Severe financial distress; chronic medical problems

Axis V. Current GAF = 70

SUMMARY OF REFERRAL QUESTIONS:

1. **What is your diagnosis?** See above. Mr. Kobs shows a pattern of cognitive performance on current and past testing that shows inconsistency, and these inconsistencies were well documented in the neuropsychologcial assessment done on 8/22/02. Based on observations and test results from the current evaluation, this examiner concurs with the opinion of the examiner from the 8/22/02 evaluation, i.e., that the pattern of deficits seen in that examination is not due

to trauamtic brain injury and that significnat [sic] emotional and/or motivational issues are very likely part of the clinical picture. The purpose of this evaluation was not to do another comprehensive assessment of Mr. Kobs' neuropsychological functioning, but rather provide a context in which to explore the possibility of symptom exaggeration [sic] the part of the client.

It was notable that of the two traditional neuropsychologial tests administered for this current evaluation (RAVLT, BCT), neither produced a pattern consistent with significant cognitive impairment, much less dementia – even if the client was exaggerating. For example, the results of the memory test (RAVLT) showed low average performance on most scores. Given this finding, along with convincing evidence from the measures of symtom [sic] exaggeration, it seems safe to conclude that the client is not suffering from dementia. Unfortunately, however, it is not possible to determine the extent of any mild deficits that might be present from a possible concussive injury five years ago.

2. **What are the objective medical findings?** Please see the narrative above, including scores from testing.

3. **What is your assessment of the claimant's subjective complaints?** Mr. Kobs appears to be genuinely concerned about his cognitive functioning, and he considers himself to have dementia, likely because he was diagnosed with that in October 2002. However, his pattern of deficits is not consistent with degenerative dementia, or dementia due to brain injury. Unfortunately, there is strong evidence that he consciously or unconsciously exaggerated symptoms for this evaluation. While one cannot automatically conclude that he showed the same pattern with the previous two neuropsychological evaluations, there is

sufficient evidence to at least question the findings. Also, it is notable that for the current evaluation, the client was obviously aware that his motivation might be suspect because one of the first things he said was to reassure the examiner that he was not going to "lie."

4. **What specific impairments (functional limitations) are present?** From the current evaluation, there are few, if any, functional limitations that can be discernable from the data because the validity of the data is suspect as it pertains to his actual cognitive abilities. There is a moderate chance that his emotional difficulties, namely depression, are contributing to his subjective cognitive problems.

5. **Is the claimant is** [sic] **unable to return to work without restrictions? If there are restrictions, please specify.** There is no clear answer to this question with the known data.

6. **If the claimant is unable to return to any job, what is the expected length of disability?** Based on the cognitive data and their assumed questionable validity, one cannot make firm predictions about his ability to return to work. It seems unlikely that his [sic] totally unfit to work, based on his subjective cognitive deficits.

7. **Is there any period of time after 7/4/02, based upon your review of the medical records, when the claimant would have been considered totally disabled?** With all likelihood, the answer is probably "No", based solely on the cognitive data.

8. **Complete the appropriate testing to elicit your opinion of the claimant's condition?** See above.

9. **Complete the *Mental Residual Functional Capacity Assessment Form.*** See attached.

All recommendations are advisory only and based upon the best professional judgment of the examiner, considering all the data available at this time. All recommendations are based on a reasonable degree of psychological certainty, as absolute predictions are not possible.

/s/ P Sarff, Ph.D.
Philip Sarff, Ph.D.
Licensed Psychologist

[LOGO]

Elite Physicians®, Ltd.

A Subsidiary of **NMR**

Providers of
Evidence-Based Medical Reports

October 15, 2002

Ms. Connie DuBose
United Wisconsin Group
P.O. Box 2013
Milwaukee, WI 53201

RE: Elvis Kobs
CLAIM #: 02103513
SS #: 387-50-4896
NMR #: D20628.01

Dear Ms. DuBose,

Thank you for referring this file for review, to determine Mr. Kobs's level of functionality. Specific issues will be addressed at the end of the report.

ORTHOPEDIC ASSESSMENT: A thorough review of the medical records was completed. According to the medical records, from an orthopedic surgeons perspective, the primary diagnosis affecting Mr. Kobs' ability to work is status post arthroscopic surgery to the left knee secondary to a fall. Other associated diagnoses are hypercholesterolemia, coronary artery disease, asthma, tobacco abuse, status-post coronary angioplasty on three separate occasions, and coronary artery disease. A final associated diagnosis is depression and anxiety.

Mr. Kobs is now status post fall from a roof at his home on or about 01/04/02. He fell approximately 30 to 35 feet. During that fall, he sustained multiple contusions, a

sprain of the left shoulder, trauma and contusion to the left ankle with contusion to the left knee. He was found to have a joint effusion of the left knee, which was now status post arthroscopic surgery; however, the arthroscopic surgical operative report was not submitted for review.

* * *

The history and physical and testing do support the diagnosis of his treating physicians; however, they are not functionally embarrassing enough from an orthopedic standpoint that would preclude him from being gainfully employed in a sedentary capacity either as an accounts manager, business manager, or finance director in car sales. Mr. Kob has problems from his alleged short-term memory and depression, which is more psychological and psychiatric in nature than orthopedic.

* * *

If you have any additional questions, please contact our office.

Sincerely,

/s/ Richard A. Silver, M.D.
Richard A. Silver, M.D.
Board of Certified Orthopedic Surgery
Fellow International College of Surgeons
Fellow American Academy of Disability
Evaluating Physicians
Fellow American College of Forensic Examiners
American Board of Forensic Medicine
IL. License # 036-040535
AZ. License # 5135

PSYCHIATRIC ASSESSMENT: A thorough review of the medical records was completed. From a psychiatric

perspective according to the medical records, the primary diagnosis affecting Mr. Kobs' ability to work is that of depression.

* * *

The history and testing support the diagnosis of his treating physician; however, according to objective evidence in the medical records, Mr. Kobs does not have a significant impairment that would prevent him from performing essential functions of his employment. There are no specific limitations regarding ability to function related to Mr. Kobs' impairments. No specific restrictions due to safety issues should be placed on Mr. Kobs. The medical records show that Mr. Kobs is receiving appropriate and regular medical care. I would not suggest any other treatments other than supportive psychotherapy.

* * *

If you have any questions or concerns regarding this evaluation, please contact our office.

Sincerely,

/s/ Reginald A. Givens, M.D.
Reginald A. Givens, M.D., Psychiatrist
Diplomate American Board of Psychiatry
and Neurology, Adult Fellowship
Training in Psychosomatic Medicine
Diplomate American Board of
Medical Consultants
IL. License # 003-036-093992-01
MO. License # MDR8N85

08/17/03 **Francine Blaha RN.** – Records received and reviewed.

* * *

SUMMARY:

Without having to go into great detail. Based on the objective medical documentation provided for review, the objective data does not even come close to the massive subjective complaints of the claimant. Uphold denial.

UWG United Wisconsin Group

P.O. Box 2013
Milwaukee, WI 53201
262-787-7400/1-800-452-4250
FAX 262-787-7575

September 4, 2003

Gerald Gust
Novitzke, Gust, Sempf & Whitley
314 Keller Avenue N
Amery WI 54001

RE: Long Term Disability – Elvis Kevin Kobs
SS#: 387-50-4896
Group #: 702273/0000

Dear Mr. Gust:

This letter is in response to your claim appeal of the denial of Long Term Disability benefits. Our Appeal Committee has reviewed the file.

The group policy states:

DEFINITION OF LONG TERM DISABILITY

"TOTAL DISABILITY" and **"TOTALLY DISABLED"** means that due to Injury and/or Illness,:

1. the Insured cannot perform the material duties of his or her regular occupation during the Elimination Period and the following 24 months of the Benefit Period; and

2. after 24 months of the Benefit Period, the Insured cannot perform any of the material duties of any gainful occupation for which he/she is or may be reasonably fitted by education, training or experience.

"PARTIAL DISABILITY" and "PARTIALLY DISABLED" means that due to Injury and/or Illness, the

Insured is unable to earn 80% of his or her monthly Indexed Pre-Disability Earnings because of that Injury or Illness and is either:

1. during the first 24 months of the Benefit Period, unable to perform all material duties of his or her regular occupation on a Full-Time basis, but is performing at least one of the material duties of his or her regular occupation or another occupation on a part-time or Full-Time basis; or

2. after the first 24 months of the Benefit Period, unable to perform the material duties of any occupation for which he or she is or may be reasonably fitted by education, training or experience.

When Totally or Partially Disabled based on objective medical findings, the Insured must be under the Regular Care and Treatment of a Physician and provide documentation of same as required by Us. The Insured may be required to see a Physician selected by Us for an independent medical examination.

A thorough review of Mr. Kobs' medical history was completed. We gathered medical information from all sources known to us, including Worker's Compensation. Our findings are that there was no significant change in Mr. Kobs' neurological symptoms, subsequent to his January 3, 2002 claims for disability. We lack objective medical evidence to support the numerous subjective complaints and find no basis for a physically disabling condition.

The Appeal Committee finds that our original decision to deny benefits was correct, under the terms of your Long Term Disability policy. No benefits are payable on Mr. Kobs' claim.

We reserve all rights and defenses, either expressly stated or implied.

This is the full and final decision of the Appeal Committee. As such, you have a right to file a civil action pursuant to section 502(a) of the Employee Retirement Income Security Act of 1974 requesting a review of our final determination.

If you have any questions, you may contact this office at 1-800-452-4250.

Sincerely,

/s/ Julie Szemborski
Julie Szemborski, FLMI, ALHC, HIA, ACS
Manager, Life & Disability Claims
United Wisconsin Group

cc: Bernard's Northtown, Inc.

STATE OF WISCONSIN POLK COUNTY
CIRCUIT COURT

Washington Mutual Bank, FA,
c/o Chase Manhattan Mortgage
Corporation (CA)
10790 Rancho Bernardo Drive
San Diego, CA 92127

Plaintiff,

v.

Elvis K. Kobs f/k/a Eugene K. Kobs
and Donna P. Kobs
65 County Road M
Star Prairie, WI 54026

Defendants.

COMPLAINT
Case No. 03 CV 165

Case Code 30404
(Foreclosure of Mortgage)
The amount claimed exceeds $5000.00

Plaintiff, by its attorneys, GRAY & END, L.L.P., pleads as follows:

1. The plaintiff is the current owner and holder of a certain note and recorded mortgage on real estate located in this county, true copies of which are attached hereto as Exhibits A and B and incorporated by reference.

2. The mortgaged real estate is owned of record by Elvis K. Kobs and Donna P. Kobs.

3. The defendants have failed to make contractual payments as required, and there is now due and owing to plaintiff the principal sum of $297,848.78 together with interest from December 1, 2002.

4. The plaintiff has declared the indebtedness immediately due and payable by reason of the default in the payments and has directed that foreclosure proceedings be instituted.

5. The mortgaged premises is a parcel of land which is less than 20 acres; with a one to four family residence thereon which is occupied as the homestead of the defendants; said premises cannot be sold in parcels without injury to the interests of the parties.

* * *

WHEREFORE, the plaintiff demands:

1. Judgment of foreclosure and sale of the mortgaged premises in accordance with the provisions of Section 846.101 of the Wisconsin Statutes.

2. That the amounts due the plaintiff from the mortgagor defendants for principal, interest, taxes, insurance, costs of suit and attorney fees be determined.

* * *

GRAY & END, L.L.P.
Attorneys for Plaintiff

By: /s/ [Illegible]
Michael M. Riley
State Bar No. 1033997
600 North Broadway
Suite 300
Milwaukee, Wisconsin 53202
(414) 224-1987

STATE OF WISCONSIN ST. CROIX COUNTY
CIRCUIT COURT

Daimler Chrysler Services of North America L.L.C. f/k/a Chrysler Financial Company L.L.C.
400 Horsham Drive
Horsham, PA 19044

Plaintiff,

vs.

Donna P. Kobs
and Elvis K. Kobs
65 County Road M
Star Prairie, WI 54026

Defendants.

COMPLAINT

(Filed Mar 31, 2003)

Case No.

Small Claims – Replevin: 31003

NOW COMES the plaintiff, by its attorneys, and alleges:

1. Plaintiff seeks to enforce a cause of action arising from a consumer credit transaction which is identified in the annexed exhibits.

2. A description of the collateral which the plaintiff seeks to recover is set forth in the annexed exhibits.

3. Defendants defaulted by having outstanding an amount exceeding one full payment which has remained unpaid for more than ten (10) days after the scheduled or deferred due dates.

4. Plaintiff is entitled to a judgment for possession of the collateral but is not seeking to recover, in this action, the balance of the credit transaction which computed as of February 5, 2003 is as follows:

a.	Amount Financed	$ 19,919.90		
b.	Total of Payments (Precomputed Credit Transaction)	$		
c.	Delinquency Charges	$ 60.00		
d.	Interest	$ 5,414.20		
e.	Other _____	$		
	DEBIT SUBTOTAL			$25,384.10
f.	Less Payments	$ 5,188.12		
g.	Less Rebate of Unearned Finance Charges in Precomputed Transaction	$		
h.	Less Amount Received From Sale of Any Collateral	$		
i.	Other _____	$		
	CREDIT SUBTOTAL			$ 5,188.12
j.	BALANCE DUE ON DEFENDANTS' ACCOUNT			$20,195.98

* * *

8. Defendants have the right to cure a default under s.425.105 pursuant to a notice given under s.425.104 upon tendering to plaintiff the total payment of $1,118.20 on or before February 24, 2003.

WHEREFORE, Plaintiff demands judgment against the defendants as follows:

(A) For possession of the collateral or goods securing the consumer credit transaction;

(B) And for the costs and disbursements of this action.

BASS & MOGLOWSKY, S.C.
Attorneys for Plaintiff

BY /s/ Joshua J. Brady
Joshua J. Brady
WI State Bar No. 1041428

Subscribed and sworn
before me on March 21, 2003

/s/ Mary Martone
Notary Public, State of WI
My commission expires:
06-19-05

P.O. Address:
7020 N. Port Washington
Road
Suite 206
Milwaukee, WI 53217
Telephone: 414-228-6700

STATE OF WISCONSIN ST. CROIX COUNTY
CIRCUIT COURT

Daimler Chrysler Services of
North America L.L.C. f/k/a Chrysler
Financial Company L.L.C.

Plaintiff,

vs.

Donna P. Kobs
and Elvis K. Kobs
65 County Road M
Star Prairie, WI 54026

Defendants.

REPLEVIN
JUDGMENT

(Filed May 2, 2003)

Case No. 03-SC-480

This action having come on for hearing before the Court on MAY 5, 2003, and the defendant having failed to Answer or otherwise appear, or having appeared, failed to state a defense to plaintiff's Complaint;

NOW, upon all of the files and proceedings had herein, and upon motion of Bass & Moglowsky, S.C., plaintiff's attorneys'

IT IS ADJUDGED THAT:

1. The plaintiff is entitled to possession of the following personal property:

1999 Chrysler LHS, ID#2C3HC56G6XH642969

2. The plaintiff is further entitled to:

a) have execution issued to require the Sheriff of the County where said property may be to take the same from the defendant and deliver it to the plaintiff; or

b) to immediately exercise its right to nonjudicial recovery of said property, subject to s.425.206 of the Wisconsin Statutes; and

c) to have and recover from the defendant Court costs and disbursements in the sum of $161.00.

JUDGMENT ENTERED THIS 13th DAY OF June, 2003, FOR POSSESSION OF COLLATERAL, AND FOR THE SUM OF $161.00.

BY THE COURT:

/s/ [Illegible]
Circuit Judge/Court Commissioner
Deputy Clerk

STATE OF WISCONSIN POLK COUNTY
CIRCUIT COURT

WM Specialty Mortgage, LLC,

Plaintiff,

v.

Elvis K. Kobs f/k/a
Eugene K. Kobs
Donna P. Kobs and
Bremer Bank,
National Association

Defendants.

ORDER CONFIRMING SALE

Case No. 03-CV-165

The Honorable Robert H. Rasmussen

Upon the application of the plaintiff through attorneys, Gray & End, L.L.P., and upon the records, files and proceedings herein,

IT IS HEREBY ORDERED that the expenses set forth in the affidavit of plaintiff's counsel are hereby added to the judgment making a total sum due to the plaintiff of $367,918.16.

IT IS FURTHER ORDERED that the sale of the mortgaged premises to the plaintiff for $367,918.16 is confirmed.

* * *

IT IS FURTHER ORDERED that the plaintiff is entitled to a writ of assistance for the removal of the defendants and/or tenants/occupants.

IT IS FURTHER ORDERED that no deficiency judgment may be awarded to the plaintiff.

Dated this 24th day of May, 2004.

BY THE COURT:

/s/ Robert H. Rasmussen
Robert H. Rasmussen
Circuit Court Judge

Attorneys for Plaintiff:
GRAY & END, L.L.P.
600 N. Broadway
Suite 300
Milwaukee, Wisconsin 53202
(414) 278-8060

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

ELVIS KOBS, **Civil #: 04-C-0005-S**

Plaintiff,

v.

UNITED WISCONSIN INSURANCE COMPANY

Defendant.

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS SECOND MOTION TO CONTINUE DEFENDANT'S SUMMARY JUDGMENT MOTION FOR ENLARGEMENT OF TIME TO REPLY TO DEFENDANT'S SUMMARY JUDGMENT MOTION and TO COMPEL DEPOSITION DISCOVERY and in OPPOSITION TO DEFENDANTS MOTION FOR PROTECTION

The Defendant, Elvis Kobs, through his attorneys, Novitzke, Gust, Sempf & Whitley, by Jason W. Whitley, have moved the court for the following relief:

1. Continuance of the Defendant's Summary Judgment Motion Hearing and Enlargement of time in which to respond to Defendant's Motion for Summary Judgment and for an order to compel the Defendant to produce witnesses for depositions.

* * *

The Plaintiff needs to learn what information was available to the Defendant at the time Plaintiff made his request for insurance disability benefits and also the manner in which the Defendant handled and processed

that claim subject to the terms and provisions of its own policy. In addition, the Plaintiff needs to know whether the Defendant, in denying the Plaintiff's claims for insurance benefits, acted in a dual capacity as both insurer of the Plaintiff and the Administrator of the plan or the policy covering such a plan. This information is necessary to determine the proper standard of review because the defendant is claiming that its coverage decisions are subject to the strict arbitrary and capricious standard which properly only applies to plan administrators. Here, the defendant does not appear to be an not an [sic] administrator but rather a mere insurance company.

Pursuant to *Firestone Tire and Rubber Co. v Bruke* [sic], 489 U.S. 101, 115 (1989), if an insurance company acts in a dual capacity which places that insurer in a perpetual conflict as to both the insurer and interpreter of the plan, then the proper standard of review is de novo. *Id.*

* * *

This is an important matter because the Defendant's Summary Judgment Motion requests a determination that the standard of review is arbitrary and capricious. It is impossible for Plaintiff to respond to the Defendant's Motion in that regard unless the Plaintiff can determine the various procedures followed by United Wisconsin Company in reviewing and refusing Mr. Kobs's insurance claim.

The proper standard of review is of great importance in ascertaining whether an insurer wrongfully denied benefits under a benefits policy. Plaintiff must be able to conduct necessary discovery before he can effectively proceed on those issues.

Therefore, because the Plaintiff cannot properly defend against Defendant's Motion for Summary Judgment without obtaining certain necessary discovery material.

Dated this 5th day of May, 2004.

/s/ Jason W. Whitley
Jason W. Whitley, #1027052
NOVITZKE, GUST, SEMPF & WHITLEY
Attorneys for Plaintiff
314 Keller Avenue North, Suite 399
Amery, Wisconsin 54001
715-268-6130

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

Elvis Kobs
65 County Road M
Star Prairie, WI 54026

Plaintiff,

v.

United Wisconsin Insurance Company
P.O. Box 2013
Milwaukee, WI 53201-2013

Defendant.

Case No: 04-C-0005-S
Assigned Judge:
John C. Shabaz

BRIEF IN SUPPORT OF DEFENDANT'S MOTION FOR PROTECTIVE ORDER

* * *

FACTS

The background facts in this case have been previously set forth in the parties' briefs on file with the Court. Further, it has been established in the Court's Memorandum and Order of February 2, 2004, that the group disability insurance policy at issue in this matter qualifies as an "employee welfare benefit plan" as that term is defined in ERISA.

During the parties' 26(f) conference on January 20, 2004, the Plaintiff's counsel, Mr. Whitley, indicated that he would request the deposition of a UWIC employee subsequent to his receiving UWIC's administrative file. Dorner Aff. ¶ 4. At that time, UWIC's counsel advised Mr. Whitley that UWIC would object to depositions because

discovery in this case is limited to the administrative file under ERISA's arbitrary and capricious standard. Dorner Aff. ¶ 4. This was documented in the parties' Joint 26(f) Report dated January 27, 2004, and on file with the Court. Dorner Aff. ¶ 4.

* * *

B. Under The Arbitrary And Capricious Standard Of Review, Discovery Is Limited To The Administrative Record.

Under the highly deferential arbitrary and capricious standard of review, consideration of evidence by the court is limited only to that which was submitted to the plan's administrator at the time the claims decision was rendered. *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975 (7th Cir. 1999) (finding that the district court erred in allowing discovery beyond the administrative record); *Winters v. UNUM Life Ins. Co. of Am.*, 232 F.Supp.2d 918, 927 (W.D. Wis. 2002). "Deferential review of an administrative decision means review on the administrative record." *Perlman*, 195 F.3d at 981-982. Inquiry into the thought processes of the administrator's staff, the training of those who considered the plaintiff's claims "and in general who said what to whom within [the administrator]" goes beyond that which is allowed under a deferential review. *Id.* The Seventh Circuit has not allowed parties to take discovery into the mental processes of the administrator's personnel in cases where an arbitrary and capricious standard governed. *Id.* at 982.

* * *

Dated this 23rd day of April, 2004.

UNITED WISCONSIN
INSURANCE COMPANY

By: Carol L. Dorner
Carol L. Dorner
State Bar. No.: 1032239

P.O. ADDRESS
401 West Michigan Street, C-10
Milwaukee, WI 53203
Phone:(414) 226-6930
Facsimile: (414) 226-6229

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MISSOURI

PAMELA E. ARMSTRONG, No. 96-0134-CV-W-2

Plaintiff,

vs.

AETNA LIFE INSURANCE
COMPANY and AETNA
HEALTH PLAN and
PLAN ADMINISTRATOR,

Defendants.

DEPOSITION OF SANDRA F. FREIBURGER, a witness, taken on behalf of the Plaintiff, pursuant to Notice, on the 6th day of December, 1996, at the offices of AETNA INSURANCE COMPANY, 151 Farmington Avenue, in Hartford, Connecticut, before

JEAN M. JUSTMAN,

of AAA Reporting Company, Kansas City, Missouri.

APPEARANCES

For the Plaintiff:
MR. M. KEVIN UNDERHILL
SHOOK, HARDY & BACON, L.L.C.
1200 Main Street
Kansas City, Missouri 64105

For the Defendants:
MR. JOHN W. COWDEN
BAKER, STERCHI, COWDEN & RICE, L.L.C.
911 Main Street, Suite 2100
Kansas City, Missouri 64105

MS. SONYA D. DOCKETT
AETNA INSURANCE COMPANY
151 Farmington Avenue
Hartford, Connecticut 06156

* * *

[61] Q. (By Mr. Underhill) We spoke earlier about the savings concept. Do you recall that?

A. Yes, I do.

Q. I don't suppose that based on a particular total of savings anybody would get a bonus. Is that possible?

MR. COWDEN: Objection. It calls for speculation.

Q. (By Mr. Underhill) You can answer it if you know.

MR. COWDEN: If you know.

A. There is that possibility.

* * *

[67] Q. Have you ever gotten a bonus that took savings into account?

A. Yes, I have.

Q. And what were you told about that?

A. It was based on savings that was identified as not eligible claims for certain plans.

Q. How was the amount of your bonus calculated?

A. I'm not sure. The performance bonus program [68] stipulates a certain – certain percentage of salary. But

that is strictly left up to the manager or supervisor's discretion, supervisor discretion.

Q. So is it accurate to say that savings is one criteria in the performance bonus program?

MR. COWDEN: Do you mean for her? Are you asking about other people?

Q. (By Mr. Underhill) Yes, for you specifically.

A. For me specifically; it was one.

Q. Would you say that it is generally one?

MR. COWDEN: I object to the form. I think it calls for speculation.

A. For some people, no.

Q. (By Mr. Underhill) Are you saying that there are some employees for whom savings is not a criteria of their performance?

A. Correct. Correct.

Q. Which employees are those?

A. The ones that I'm aware of, administrative assistants, processors, customer service, member service, nurses. And that's generally speaking.

* * *

[71] Q. Can you explain what you mean by that a little bit more?

A. Your merit increase is based on your performance objectives, meeting your performance objectives.

Q. One of those objectives in your case being savings, correct?

A. Yes.

Q. When did you receive this bonus?

MR. COWDEN: Well, I object to the form of the question, using the term bonus, because the witness just used a different term. So I think it misstates her testimony. She said it was a merit increase.

Q. (By Mr. Underhill) When did this merit increase –

A. I received merit increases both in '94 –'95 for '94 and '96 for '95, as an annual merit review, a merit increase.

[72] Q. But haven't you testified that one of the criteria that went into those increases was savings?

A. One, yes.

Q. And you said you got such an increase in 1996 for 1995; is that right?

A. Correct.

Q. How many performance objectives did you have?

A. Five.

Q. And what were they?

A. I don't know if I can name all five. I can only do it because I know it visually. Medical underwriting production requirements met. Claim savings. Office service results. Project success. An example would be transition of business into other offices and the success of that. I'm

sorry. I can't flip over to the next page. I don't – I don't know.

Q. What are production requirements?

A. Turnaround time, volume per person. Utilization of resources; making sure that people are doing what they can in the allotted amount of time.

Q. When they evaluate this criteria of claims savings, how is it presented to you in your evaluation?

[73] A. As a per member per month.

Q. What does that mean?

A. The number of members divided by the claim volume gives you a PMPM, or per member per month.

Q. So do you mean a number of members covered by a particular group plan?

A. No, the entire market that I was responsible for.

Q. What would a member of that market be?

A. In the small business market, any employers insured by Aetna with employees of 300 and less.

Q. So Cohen Esrey would have been a member?

A. Yes.

Q. What period of time would you receive bonuses for? What I mean to say is, did you get these reviews quarterly or yearly?

A. Annual. And I was fortunate enough to receive one every year.

Q. Why is it calculated per month, if you were given the bonuses annually; do you know?

A. That's just an internal reporting actuarial. Actuary needs a member per month so they can determine trends and then set premiums appropriately; and if they need to do any [74] refiling of a certain premium increase, that can be taken care of.

Q. So is it fair to say that bonuses were awarded based in part on claims savings during 1995?

MR. COWDEN: I object –

A. Yes.

* * *

[76] Q. Which of your employees had claims savings as one of their performance objectives?

A. Fred Baruffi had a PMPM. And Deb DeForrest had a claim savings.

Q. So Fred Baruffi was one of your employees.

A. Uh-huh.

Q. Did you give him a merit increase in 1996 for 1995?

A. Yes, I did.

Q. How is claims savings calculated?

A. The PMPM.

Q. What does that mean?

A. The claims –

Q. I'm sorry, what is PMPM?

A. PMPM is the per member per month, which is the total claim volume divided by the claim dollars paid out equals per member per month in dollars.

Q. And that appears as a numerical ratio on –

A. Yes, it does.

Q. – an employee's evaluation?

A. Yes.

* * *

EXHIBIT 8

PRIVILEGED

Provident Internal Memorandum

To: *IDC Management Group*
Glenn Felton
From: *Jeff McCall*
Date: *October 2, 1995*
Re: *ERISA*

[Jeff, Looks good. See comment on last page.
/s/ Ken D.
10/4/95]

A task force has recently been established to promote the identification of policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, Glenn Felton identified 12 claim situations where we settled for $7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $0.5 million.

In order to take advantage of ERISA protection, we need to be diligent and thorough in determining whether a policy is covered. Accordingly, I have attached a rough draft of questions that should be asked in our claim investigation process. I recommend that it be used for *all* claims. The key for determining the applicability of ERISA is whether or not the employer "sponsors" or "endorses" the plan. If the employer *pays* the premium, the policy would usually, but not always, be considered to

be governed by ERISA. Salary allotment or payroll deduction arrangements, by themselves, do not necessarily mean that a policy is subject to ERISA. While our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action.

Another requirement needed in order to take advantage of the protection offered by ERISA, is to establish a formal appeal process for ERISA situations. When we deny a claim, we must include language in our letter that informs the claimant of the right to appeal our decision within 60 days. I have attached a copy of sample language. The appeal must be in writing and should be reviewed by a panel specifically established to review ERISA appeals. I recommend that the panel be composed of Chris Kinback, Bob Parks, Becky Absher, Tom Timpanaro and me.

We will be modifying the salary allotment agreements used at the point of sale to include endorsement language.

I am interested in any comments or feedback you may have on this issue.

JM:ajr

* * *

EXHIBIT 9

INDIVIDUAL	Ralph W. Mohney, Jr., Vice President	1194
DISABILITY	Jeff McCall, AVP	1947
CLAIMS	Ed Nanney, Legal Counsel	8243
	Tammy Weaver, Paralegal	7878
	Andrea Ridge, Exec. Secretary	1803
	Doug Freytag, VP Field Claims	1465
	Lisa Sager, Secretary	8328

* — * *

No. 05-394

In The
Supreme Court of the United States

ELVIS KOBS,

Petitioner,

v.

UNITED WISCONSIN INSURANCE COMPANY,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION

MARY C. NASH
UNITED WISCONSIN INSURANCE COMPANY
401 W. Michigan Street
Milwaukee, WI 53203
(414) 226-6510

MARK E. SCHMIDTKE*
SCHMIDTKE HOEPPNER CONSULTANTS LLP
103 East Lincolnway
P.O. Box 2357
Valparaiso, IN 46384
(219) 464-4961

*Counsel of Record

Counsel for Respondent

COCKLE LAW BRIEF PRINTING CO (800) 225-6964
OR CALL COLLECT (402) 342-2831

PARTIES TO THE PROCEEDING AND STATEMENT PURSUANT TO RULE 29.6

The petitioner is Elvis Kobs. The respondent is United Wisconsin Insurance Company ("UWIC"). UWIC is a Wisconsin stock insurance corporation organized pursuant to Ch. 611, Wisconsin Statutes. UWIC is a subsidiary of Compcare Health Services Insurance Corporation ("CHSIC"), a Wisconsin stock insurance corporation organized pursuant to Ch. 611, Wisconsin Statutes. CHSIC is a subsidiary of Blue Cross Blue Shield of Wisconsin ("BCBSWi"), a Wisconsin stock insurance corporation organized pursuant to Ch. 611, Wisconsin Statutes. BCBSWi's parent company is Crossroads Acquisition Corp. ("Crossroads"), a Delaware corporation. Crossroads is a subsidiary of Anthem Holding Corp. ("Anthem"), an Indiana corporation. Anthem's corporate parent is WellPoint, Inc., a publicly traded corporation organized and existing under the laws of the state of Delaware.

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RESPONDENT'S BRIEF IN OPPOSITION

This case is not an appropriate vehicle for resolving either of the issues raised in the Petition. It is not appropriate for resolving whether and under what circumstances an insurer generally has a conflict of interest when deciding ERISA benefit claims, because the facts of this case show that Respondent acted without bias in denying Petitioner's claim. Petitioner's argument that all insurers always act under an "inherent" conflict ignores the fact that, in deciding the claim in this case, Respondent engaged in an extensive claim review process, employed independent experts, relied on opinions generated by at least one doctor who was retained at the suggestion of Petitioner's own physician, and otherwise acted impartially. Both the district court and the Seventh Circuit emphasized these facts in upholding the denial, directly rebutting Petitioner's argument that these courts ignored any potential for bias. Thus, regardless of whether or not an "inherent" conflict exists with respect to insurers generally, any conflict was more than neutralized in this case.

Another reason that this case is not an appropriate vehicle for resolving the issue of when a conflict of interest arises is because, by failing to appeal the district court's discovery order, Petitioner waived any opportunity to develop evidence of either (1) actual bias beyond any alleged "inherent" conflict or (2) that such a conflict had an impact on the denial of Petitioner's claim. Petitioner argued to the district court that it was "impossible" to respond to Respondent's motion for summary judgment without a deposition of one of Respondent's employees. However, after the district court entered a protective order and Petitioner responded to the summary judgment

motion and lost, Petitioner never appealed the district court's discovery ruling. At this point, any opportunity to conduct discovery on the issue of bias has been waived. Although one cannot predict how this Court might resolve this issue, if this Court were to rule that something more than an "inherent" conflict is necessary to impact the abuse of discretion standard, such a decision will have no effect on this case because Petitioner has waived any opportunity to meet such a standard.

This is also not an appropriate case for resolving the second issue presented in the Petition, i.e., what impact a conflict of interest should have on the abuse of discretion standard. The strong evidence supporting Respondent's denial makes it highly unlikely that the courts below would have overturned the denial, even if less deference were applied by those courts. The district court ruled that there was "near unanimous" evidence that Petitioner's orthopedic claim was not disabling and that there was "overwhelming" evidence that Petitioner's cognitive complaints were exaggerated and that he was not cognitively disabled. The Seventh Circuit agreed, observing with respect to the cognitive claim, that at least three experts determined that Petitioner was "sandbagging" during testing, including a neuropsychologist who tested Petitioner on a referral from Petitioner's own doctor. Overall, the Seventh Circuit held that the "bulk of the evidence" supported Respondent's decision, noting that while Petitioner's claim was supported by his primary care doctor and a psychologist, "[o]n the other side of the scale were the opinions of two orthopedic surgeons, two psychologists, a psychiatrist/neurologist, and a registered nurse." In light of the lower courts' decisions that the record evidence weighed heavily in favor of Respondent's

denial, any adjustment of the amount of deference accorded under the abuse of discretion standard based on an "inherent" conflict of interest, will not likely change the final result in this case. In short, as applied to the facts in this case, the issues raised in the Petition are merely academic and the Petition should be denied.

JURISDICTION

This Court has discretionary jurisdiction to review decisions by the federal courts of appeals. 28 U.S.C. § 1254(1). For the reasons set forth herein, Respondent submits that this Court should not exercise this jurisdiction.

STATUTES INVOLVED

This case involves the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1001, *et seq.* ("ERISA").

COUNTERSTATEMENT OF THE CASE

Factual Background. Petitioner worked as a Business Manager for a car dealership. His occupation was sedentary, requiring Petitioner to sit eighty percent of the day, stand twenty percent of the day, and lift no more than five pounds. As a benefit of his employment, Petitioner participated in a long-term disability plan, the benefits of which were administered and insured by Respondent. Total disability benefits under the plan were payable for

up to 24 months where the employee "cannot perform the material duties of his or her regular occupation" and thereafter if the employee "cannot perform any of the material duties of any gainful occupation for which he/she is or may be reasonably fitted by education, training or experience." (P App 34a)[1]

On January 4, 2002, Petitioner was injured in a fall. Six months later, in June 2002, he underwent an angioplasty after episodes of chest pains. Petitioner received short-term disability benefits from January 4 through July 4, 2002. He then sought long-term disability benefits, alleging that he was disabled due to memory loss from prior incidents in 1998 and 1999, and that this condition was exacerbated by the fall in 2002.

After reviewing pertinent medical records, Respondent denied the long-term disability claim. The decision was based in large part on a review of Petitioner's medical information by independent physicians, board certified in orthopedic surgery and psychiatry/neurology. Following receipt of Respondent's denial letter, Petitioner filed an administrative appeal.

During the appeal stage, Petitioner submitted additional medical records and information. Respondent then requested another review of Petitioner's file by an independent physician and gathered various documents, including records from the State of Wisconsin, Department of Workforce Development, related to a worker's compensation claim that arose from the alleged incidents in 1998 and 1999. Respondent also requested an independent

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[1] Citations to Petitioner's appendix are noted as "P App ___." Citations to Respondent's Appendix are noted as "R App ___."

psychological evaluation of the Petitioner and had a registered nurse complete an exhaustive review of the medical records and related documents in Petitioner's claim file, which at that point included notes for the time period of 1966 to 2003. At the time of Respondent's final decision, among other things, the claim file contained the following medical evidence and opinions regarding Petitioner's orthopedic complaints:

> *Neal A. Melby, M.D.:* Dr. Melby is Petitioner's primary care physician. Dr. Melby opined on several occasions that Petitioner was disabled both due to back and leg injuries and due to memory loss. (P App 54a-61a)
>
> *Thomas V. Reiser, M.D.:* Dr. Reiser saw Petitioner following an incident in 1999 and then again in May 2002, in connection with Petitioner's worker's compensation claim. After "reviewing the available information," Dr. Reiser opined that Petitioner "has a permanent partial disability of 4% to the body as a whole for his cervical condition based on Wisconsin Worker's Compensation Statutes." (P App 70a)
>
> *Nolan M. Segal, M.D.:* Dr. Segal is an orthopedic surgeon who performed an independent medical examination of Petitioner on January 2, 2003 in connection with Petitioner's worker's compensation claim. Among other things, Dr. Segal concluded that "I find evidence from a musculoskeletal standpoint to suggest symptom magnification and functional overlay, and find evidence to suggest that his subjective complaints are not in fact consistent with objective examination findings or radiologic findings." He opined that "[t]here is . . . no evidence that [Petitioner] would be considered disabled from gainful employment from a musculoskeletal standpoint." (P App 75a)

> *Richard A. Silver, M.D.:* Dr. Silver is an orthopedic surgeon who reviewed Petitioner's medical records at the request of Respondent. He concluded that the "history and physical and testing do support the diagnosis of his treating physicians; however, they are not functionally embarrassing enough from an orthopedic standpoint that would preclude him from being gainfully employed, in a sedentary capacity either as an accounts manager, business manager, or finance director in car sales." Dr. Silver also opined that Petitioner was "fit for duty at a sedentary light capacity . . . from an orthopedic perspective." (P App 89a)

The claim file also contained the following medical evidence and opinions regarding Petitioner's psychiatric/psychological complaints:

> *Mary K. Fisher, Psy. D.:* Dr. Fisher is a psychologist who saw Petitioner on a referral from Dr. Melby. Dr. Fisher performed psychological tests on Petitioner on November 22, 2002. She concluded that Petitioner "suffer[ed] from deficits in executive functioning including sequencing, planning, mental organization, and metal [*sic*] deficits" and that Petitioner "meets the criteria for a DSM-IV diagnosis of dementia due to traumatic brain injury." (P App 66a)

> *Reginald A. Givens, M.D.:* Dr. Givens is a psychiatrist who reviewed Petitioner's medical records at the request of Respondent. In a report dated October 15, 2002, he concluded that the history and testing did support the diagnosis of the treating physician, but "according to objective evidence in the medical records, [Petitioner] does not have a significant impairment that would prevent him from performing essential functions of his employment" and that "[t]here are no specific limitations regarding ability to function related to [Petitioner's] impairments." (P App 90a)

Mary Sullivan, Ph.D., L.P.: Dr. Sullivan is an Assistant Professor of Neurology at the University of Minnesota Medical School. Dr. Sullivan performed a neuropsychological evaluation of Petitioner on August 22, 2002 based on a referral from Petitioner's primary care physician, Dr. Melby. Dr. Sullivan concluded that "[t]here was in fact no real evidence that he had sustained a closed head injury, e.g., an injury that would have produced cognitive effects" and that the testing results "were not consistent with the presence of memory problems secondary to a closed head injury." (R App 63a-64a)[2] Dr. Sullivan also noted "numerous implausible aspects of [Petitioner's] performance which raise questions about the effort he exerted throughout this evaluation." Specifically, Dr. Sullivan observed:

> First of all, [Petitioner's] IQ, as measured here, was found to be 80, that is, just barely within the low average range. This is simply not believable. There is no possible way that a head injury of the severity described by [Petitioner] could have lowered his IQ to this level. Furthermore, there were findings within the IQ testing that were also highly unlikely. [Petitioner] obtained a score on Vocabulary, which measures knowledge of vocabulary, that was in the low average range. This seems unusually low for a man who finished two years at Boston College and who used to make speeches and sell cars . . . Furthermore, knowledge of vocabulary is pretty invulnerable to the effects of a mild head injury . . . Third, [Petitioner] got just one item right on the Picture Arrangement – the first item. He then failed the next four items.

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[2] Petitioner's appendix includes only excerpts from Dr. Sullivan's report. The full report is included in Respondent's appendix at 39a-65a.

> This is a highly unusual performance, even for people who are mentally retarded. [Petitioner], even given how poorly he performed, is clearly not mentally retarded.

(R App 59a-60a)

Philip Sarff, Ph.D.: Dr. Sarff is a psychologist. Respondent retained him to examine and test Petitioner and to review Petitioner's medical records. The examination was performed on March 28, 2003. Dr. Sarff's findings echo those of Dr. Sullivan. He noted "a pattern of cognitive performance on current and past testing that shows inconsistency, and these inconsistencies were well documented in the neuropsychological assessment done on 8/22/02." (P App 84a) Among other things, Dr. Sarff noted that the results of memory testing showed low average performance on most scores and that "[g]iven this finding, along with convincing evidence from the measures of symtom [*sic*] exaggeration, it seems safe to conclude that the client is not suffering from dementia." (P App 85a) Dr. Sarff continued:

> [Petitioner's] pattern of deficits is not consistent with degenerative dementia, or dementia due to brain injury. Unfortunately, there is strong evidence that he consciously or unconsciously exaggerated symptoms for this evaluation. While one cannot automatically conclude that he showed the same pattern with the previous two neuropsychological evaluations, there is sufficient evidence to at least question the findings. Also, it is notable that for the current evaluation, the client was obviously aware that his motivation might be suspect because one of the first things he said was to reassure the examiner that he was not going to 'lie.'

(P App 85a-86a) The registered nurse retained by Respondent to review the entire contents of Petitioner's file concluded that "[b]ased on the objective medical documentation provided for review, the objective data does not even come close to the massive subjective complaints of the claimant." (P App 91a) Respondent upheld the denial of long-term disability benefits.

Proceedings Below. On November 26, 2003, Petitioner filed this action in state court, pleading a claim for state law breach of contract. (R App 1a-3a) Plaintiff also served a "Demand to Produce" on Respondent, seeking information in Respondent's claim file and a copy of the relevant disability policy. Respondent removed the matter to federal court and filed a motion to dismiss, arguing that Petitioner's state law claim was preempted by ERISA, 29 U.S.C. §1144(a). Petitioner responded by requesting leave to amend his complaint to plead a claim for benefits under ERISA, although Petitioner contended that his state law claim was not preempted by ERISA.[3] (R App 4a) Plaintiff's amended complaint included ERISA and state law claims. (R App 6a-11a)

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[3] Petitioner argued that ERISA preemption only applies when a benefit plan is "self-funded" and that it does not apply to insured ERISA plans. Petitioner's argument ignored the statutory definition of an "employee welfare benefit plan" which broadly includes plans that are funded "through the purchase of insurance or otherwise." 29 U.S.C. §1002(1). He also ignored decisions of this Court that apply ERISA's preemption provision to state law breach of contract and other claims that arise out of insured ERISA plans. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

Shortly after removal, the parties filed their Rule 26(f) Joint Scheduling Report. (R App 12a-15a) It was Petitioner's position that he would conduct the deposition of at least one person involved in the denial of Petitioner's disability benefit claim. Respondent stated that it would object to any depositions.[4] Both parties stated that they contemplated filing motions for summary judgment. (R App 12a, 13a-14a)

On January 27, 2004, the district court issued its Preliminary Pre-Trial Conference Order, setting a deadline for motions for summary judgment of May 1, 2004 and a discovery deadline of June 10, 2004. (R App 16a-17a) On February 2, 2004, the district court issued its Memorandum and Order dismissing Petitioner's state law cause of action as preempted by ERISA and allowing Petitioner to proceed with his ERISA benefit claim. (R App 18a-24a) On February 19, 2004, Respondent responded to Petitioner's "Demand for Production" by agreeing to produce the policy and the administrative record/claim file.

On April 5, 2004, Respondent filed its motion for summary judgment. Respondent contended that, based on the evidence in the administrative record, its decision to deny Petitioner's benefit claim was not arbitrary and capricious or an abuse of discretion.[5] Petitioner sought an

---

[4] In the Seventh Circuit, as in other circuits, where an abuse of discretion standard is applicable, a court's review of a decision to deny ERISA plan benefits is limited to the evidence that was before the decision maker at the time of the determination. *See, e.g., Perlman v. Swiss Bank Corp. Long Term Comprehensive Dis. Protection Plan*, 195 F.3d 975, 981-82 (7th Cir. 1999). Because admissible evidence is so limited, Respondent took the position that discovery is likewise limited.

[5] The deferential review standard in the Seventh Circuit is termed an "arbitrary and capricious" standard rather than an "abuse of discretion" standard. The Seventh Circuit has ruled that the two

(Continued on following page)

extension to respond, stating that he intended to take a deposition of one of Respondent's representatives. Respondent moved for a protective order, arguing that any evidence obtained in the deposition was beyond the scope of admissible evidence in an ERISA benefit proceeding and that Petitioner had not timely noticed the deposition. (R App 25a-26a; 27a-34a) Petitioner responded, contending that he needed the deposition to determine if Respondent was acting in a "dual capacity" in processing Petitioner's benefit claim and that without the deposition, "the Plaintiff is unable tc determine whether [Respondent] acts as the insurer, interpreter, and the administrator of [Petitioner's] insurance policy. . . ." Petitioner argued that it was "impossible for Plaintiff to respond" to the motion for summary judgment without the deposition. (R App 36a, 37a)

On May 5, 2004, the district court granted Respondent's motion for protective order, ruling that "a deposition is not required to determine the administration [*sic*] record in this matter." (P App 19a) On May 12, 2004, Petitioner responded to the motion for summary judgment. He argued that Respondent acted in a dual role as administrator and insurer and that this should result in either a *de novo* review standard or a "sliding scale." Other than the alleged "dual role," Petitioner presented no evidence or arguments to support an alleged conflict of interest, nor did he present any arguments or evidence that an alleged conflict had any impact on the benefit denial.

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standards are equivalent. *See, e.g., Fritcher v. Health Care Service Corp.*, 301 F.3d 811, 816 n.4 (7th Cir. 2002) ("We note in passing that a previous decision from a panel of this court once noted a distinction between the 'arbitrary and capricious' standard of review and the 'abuse of discretion' standard of review . . . As we have subsequently pointed out, however, this appears to be a distinction without a difference.").

On May 28, 2004, the district court granted summary judgment in favor of Respondent. The court concluded that Respondent's decision was "amply supported by extensive medical records;" that the medical evidence "was in near unanimous support of the conclusion that plaintiff was not disabled as a result of any orthopedic conditions;" and that "the overwhelming weight of the medical evidence ... suggested that plaintiff's complaints were exaggerated and that he did not have significant cognitive impairment," including "the conclusions of Dr. Sullivan who was independent and not hired by defendant." (P App 16a)

The Seventh Circuit affirmed. The court noted that Petitioner's claim was supported by his family doctor and by a psychologist who saw Petitioner on a referral from Petitioner's family doctor. However, "[o]n the other side of the scale were the opinions of two orthopedic surgeons, two psychologists, a psychiatrist/neurologist, and a registered nurse." (P App 4a) The court quoted from several of the medical reports, including the conclusion that "there is strong evidence that [Petitioner] consciously or unconsciously exaggerated symptoms for this evaluation." (P App 5a) The court emphasized the findings of Dr. Sullivan, who was not on Respondent's payroll and who saw Petitioner on a referral from Petitioner's own doctor, and who "was also the first of three medical experts who questioned whether [Petitioner] was sandbagging during the tests." (P App 7a) Ultimately, the court of appeals stated as follows regarding Respondent's decision:

> [Respondent] gathered and reviewed the pertinent medical information, hired a number of physicians to evaluate [Petitioner] and review his medical files, and made an informed judgment about [Petitioner's] long-term disability application that coincided with the

> bulk of the medical evidence. When [Petitioner] appealed the initial determination, [Respondent] accepted additional medical information submitted by [Petitioner], had another psychologist evaluate [Petitioner], and hired a nurse to review [Petitioner's] entire file. Given this exhaustive process, [Respondent's] reasonable conclusions, and the absence of evidence of bad faith or conflict of interest, there is no basis to disturb [Respondent's] benefits determination.

(P App 9a)

REASONS FOR DENYING THE WRIT

The Petition raises two questions: (1) when and under what circumstances does an ERISA claim administrator that is also an insurer have a conflict of interest when deciding benefit claims?; and (2) what impact does such a conflict have on a court's application of the abuse of discretion standard?[6] Resolving one question without also resolving the other would provide the lower courts with little guidance. Unfortunately, the facts in this case make it a poor vehicle for resolving either one of these questions.

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[6] During the last term, this Court denied at least three petitions for writs of certiorari raising questions related to the conflict of interest of ERISA claim administrators – petitions that were filed by parties representing varied interests, including plan participants, self-funded plan sponsors, and plan insurers. *See Unum Life Insurance Company of America v. Fought*, No. 04-1000 (petition filed by benefit plan insurer in case decided by the Tenth Circuit); *Merck & Co. v. Epps-Malloy*, No. 04-995 (petition filed by self-funded plan sponsor and the plan's claim administrator in case decided by the Third Circuit); *Peach v. Ultramar Diamond Shamrock*, No. 04-919 (petition filed by claimant/plan participant in case decided by the Sixth Circuit).

I. THIS IS NOT AN APPROPRIATE CASE FOR RESOLVING WHEN AND UNDER WHAT CIRCUMSTANCES AN INSURER HAS A CONFLICT OF INTEREST GENERALLY BECAUSE THERE IS SUBSTANTIAL EVIDENCE OF RESPONDENT'S IMPARTIALITY IN DENYING PETITIONER'S CLAIM AND BECAUSE PETITIONER HAS WAIVED ANY OPPORTUNITY TO DEMONSTRATE BIAS BEYOND THE MERE FACT THAT RESPONDENT IS AN INSURER.

A. Because the Seventh Circuit Rejects "One Size Fits All" Assumptions about Alleged Insurer Bias, the Conflict of Interest Analysis in Each Case is Highly Fact-Sensitive.

Petitioner's criticism that the Seventh Circuit relies on "unsubstantiated economic assumptions" is not only ironic, but also misses the entire point of the Seventh Circuit's position on the conflict of interest issue. Petitioner's argument is ironic because the very basis of Petitioner's own argument is the unsubstantiated economic assumption that all insurers are always biased and that they always act in exactly the same biased way when determining benefit claims, regardless of the actual evidence in a particular case. The argument also misses the point of the Seventh Circuit's position, which is that the court refuses to engage in economic assumptions, one way or the other, and instead presumes neutrality unless the claimant demonstrates that the decision maker was biased and that this bias had an impact on the benefit denial.

The Seventh Circuit has repeatedly recognized that insurers experience countervailing business pressures when deciding benefit claims. On the one hand, insurers

are in business to make a profit and it is not impossible that there may be a temptation in some cases to deny borderline claims. *See, e.g., Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406, 408 (7th Cir. 2004). On the other hand, the Seventh Circuit also recognizes that, in order to compete in the marketplace, there is pressure to pay claims because insurers recognize that overly "tight-fisted" claims decisions may discourage employers from buying their policies. *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir. 1998) ("Companies ... who choose which group insurance policies they will use to fund their plans ... have the sophistication and bargaining power necessary to take their business elsewhere if an insurer ... consistently denies valid claims."). Likewise, because insurers are generally well diversified, must maintain reserves, and are well funded, the impact of granting or denying benefits in a given case, "is miniscule compared to [the insurer's] bottom line." *Id.* at 1021; *Leipzig*, 362 F.3d at 409. Furthermore, there are various forms of insurance arrangements that affect who is ultimately liable for a benefit such that blanket assumptions about insurance arrangements generally may not be valid in a given case. *Leipzig*, 362 F.3d at 408 (some insurance arrangements contain adjustments in benefit rates and/or premium costs that "compensate employees for the risk of self-interested behavior"); *Perlman v. Swiss Bank*, 195 F.3d at 981 (discussing retrospectively rated insurance arrangements whereby benefit costs are reimbursed by the employer). The Seventh Circuit has also noted that a denial that turns on unique factual evidence, like the present case, is likely to have less overall impact on an insurer than a denial that turns on broader issues of policy interpretation that can potentially affect other claims. *Cozzie v.*

Metropolitan Life Ins. Co., 140 F.3d 1104, 1108 (7th Cir. 1998) ("Indeed, it has not been demonstrated that MetLife has a direct stake, in terms of its own financial health, in the outcome of this issue of interpretation."). Finally, the Seventh Circuit has questioned whether one can make a valid assumption in every case that an insurer's corporate profit motive actually impacts the individual employees who decide claims. *Perlman*, 195 F.3d at 981 ("[I]t is unsound for the judiciary automatically to impute the plan administrator's position to the person who decides on its behalf.").

Although the Seventh Circuit refuses to engage in general assumptions about insurer bias, the Seventh Circuit does consider the possibility that a given insurer may let partiality influence its decision in a specific claim. The court will consider "specific evidence of actual bias that there is a significant conflict." *Mers*, 144 F.3d at 1020. This includes evidence that "an insurer or plan administrator pays its staff more for denying claims than for granting them." *Leipzig*, 362 F.3d at 408-09. In other words, in each individual benefit dispute, if there is evidence that a decision was impacted by bias, the Seventh Circuit will consider that evidence and will adjust the amount of deference accordingly. If there is no such evidence, the Seventh Circuit will not engage in unsubstantiated assumptions about what may or may not have motivated the decision. Each ERISA benefit case in the Seventh Circuit stands on its own facts.

B. This Case is a Poor Vehicle for Deciding Whether or Not Insurers Generally Have an "Inherent" Conflict Because the District Court and the Seventh Circuit Emphasized that the Specific Facts of this Case Demonstrated that Respondent Acted Impartially.

Ignoring the specific facts in the present case, Petitioner contends that all insurers should always be clothed with the assumption that they act under perpetual "inherent" conflicts of interest. The problem with this argument is that, in this case, the record evidence contains multiple indications of Respondent's impartiality. First, even though substantial procedural defects in a claim decision can be evidence of potential bias,[7] there is no evidence of any substantial procedural defects in the processing of Petitioner's claim. To the contrary, the review process involved volumes of medical records, reviews and examinations by multiple experts in varied specialties, and the process was, by all accounts, extensive. Second, rather than merely relying on its own employees, Respondent retained several independent medical experts to review Petitioner's records and to examine and evaluate Petitioner. Many courts hold that reliance on independent experts is evidence that a decision is impartial.[8] Finally,

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[7] *See, e.g., Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160-61 (8th Cir. 1998) (Less deference may be accorded where a procedural irregularity "caused a serious breach of the plan administrator's fiduciary duty" and "has some connection to the substantive decision reached.")

[8] *See, e.g., Fought v. Unum Life Ins. Co. of America*, 379 F.3d 997, 1015 (10th Cir. 2004), *cert. denied*, No. 04-1000 (May 2, 2005) ("Where . . . a conflict of interest may impede the plan administrator's impartiality, the administrator best promotes the purposes of ERISA by obtaining an independent evaluation."); *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1148 (7th Cir. 1998) ("Seeking independent expert advice is

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Respondent relied on opinions from doctors to whom Petitioner was referred by his own primary care physician. Certainly, Petitioner cannot allege bias on the part of experts who examined Petitioner at the direction of his own doctor.

The record also directly refutes Petitioner's contention that the district court and the Seventh Circuit completely ignored any potential for a conflict of interest. To the contrary, both courts were careful to note evidence of impartiality. In its summary of the evidence, the district court specifically noted with respect to each medical professional, the means by which each expert was retained and by which party. (P App 12a-14a) Concluding that "overwhelming" evidence supported the decision that Petitioner's cognitive complaints were exaggerated and not disabling, the district court also noted that this conclusion was "particularly" supported by Dr. Sullivan "who was independent and not hired by defendant." (P App 16a) Obviously, the district court kept its "eyes peeled" for potential bias.

Affirming the district court, the Seventh Circuit also made several comments indicating that it carefully considered the potential for bias. Responding to Petitioner's argument that the court should defer to his primary care doctor, the court noted that the primary care doctor's opinions were contradicted by the opinions of specialists and that Petitioner made no effort to address the opinions that undermined his primary care doctor. (P App 6a) The court also specifically noted that Petitioner's primary care physician referred

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evidence of a thorough investigation."); *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 234 (4th Cir. 1997) (reliance on independent medical experts "greatly mitigates" any conflict of interest).

Petitioner to two of the psychologists who performed tests, and that one of them, Dr. Sullivan, was "the first of three medical experts who questioned whether [Petitioner] was sandbagging during the test." (P App 7a) Finally, the Seventh Circuit made the point that Respondent rendered its decision only after gathering and reviewing pertinent medical information, that Respondent hired a number of physicians and other professionals to examine Petitioner and to review his records, that Respondent employed an "exhaustive process" in evaluating Petitioner's claim, and that Respondent's decision was rendered free of any evidence of bad faith or conflict of interest. All of this shows that the courts did not ignore the potential for bias, but instead carefully noted the substantial evidence that the decision was rendered free of any partiality. Whatever this Court might ultimately determine as to whether or not insurers in general have an "inherent" conflict of interest, the facts in this case demonstrate that any such "inherent" conflict was more than neutralized and that any decision regarding when a conflict of interest exists generally will likely have no impact on the judicial review standard applied in this case.

C. Even Ignoring the Substantial Record Evidence of Respondent's Impartiality, if this Court Decides that Something More than a Mere "Inherent" Conflict is Needed before there is any Impact on the Abuse of Discretion Standard, Petitioner has Waived any Opportunity to Obtain any Evidence of Actual Bias Because He Failed to Appeal the District Court's Discovery Order.

In the district court, Petitioner contended that he needed the deposition of one of Respondent's employees to

determine if Respondent was acting in a "dual capacity." He also argued that without the deposition, "the Plaintiff is unable to determine whether [Respondent] acts as the insurer, interpreter, and the administrator of [Petitioner's] insurance policy. . . ." (P App 36a, 37a) In fact, Petitioner argued that it was "impossible for Plaintiff to respond" to the motion for summary judgment without the deposition. (P App 37a) The district court denied Petitioner's request and granted Respondent's motion for protective order. Contrary to his representations to the district court, it was not "impossible" for Petitioner to argue that Respondent had an inherent conflict, because that is exactly what Petitioner did argue to the district court, the court of appeals, and in his Petition before this Court.

As Petitioner recognizes, an "inherent" conflict is not enough in the Seventh Circuit, and Petitioner was required to show that an actual conflict impacted the denial. In some circuits, although a court's review of the substantive evidence in an ERISA claim is limited to the record developed before the claim administrator, a claimant may submit evidence outside of the administrative record regarding certain tangential issues, such as a potential conflict of interest.[9] Petitioner argues that the Seventh Circuit does not permit discovery into the conflict of interest issue. Assuming this is true, Petitioner's appeal to the Seventh Circuit would have offered a perfect opportunity for Petitioner to challenge that rule. Nevertheless,

[9] *See, e.g., Wilkins v. Baptist Healthcare System*, 150 F.3d 609, 618 (6th Cir. 1998) (an exception to the principle of not receiving new evidence at the district court level is when consideration of the evidence is necessary to resolve alleged bias on the part of the claim administrator).

Petitioner did not appeal the discovery ruling and that issue is now waived.[10]

The problem that Petitioner's waiver presents in terms of whether to grant the Petition is that it substantially narrows the range of holdings that are likely to impact this case. If this Court rules that an ERISA claimant is required to prove something more than an "inherent" conflict in order to modify the abuse of discretion standard, such a decision will make no difference in this case because Petitioner has not preserved his opportunity to meet this standard.

Apparently realizing that the record in this case is bereft of any evidence of bias (in fact, the record contains substantial evidence that Respondent was not biased), Petitioner attempts to submit materials from other cases, even though none of the materials relate to Respondent. At most, the deposition in *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263 (8th Cir. 1997) shows that the insurer in that case had a potential conflict because the insurer allegedly compensated its claim personnel for denying claims. The Seventh Circuit has indicated that it would consider such evidence if submitted in connection with a particular claim decision. *Leipzig*, 362 F.3d at 409 ("Unless an insurer or plan administrator pays its staff more for denying claims than for granting them, the people who actually implement these systems are impartial."). However, there is no such

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[10] Failure to raise an issue on appeal constitutes waiver of any claim of error with respect to the lower courts' decisions on that issue. *See, e.g., HA-LO Indus. v. CenterPoint Props. Trust*, 342 F.3d 794, 801 (7th Cir. 2003); *Kauthar SDN BHD v. Sternberg*, 149 F.3d 659, 668 (7th Cir. 1998). "Where issues are neither raised before nor considered by the Court of Appeals, the Supreme Court will not ordinarily consider them." *Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206, 213 (1998); *see also Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 147, n.2 (1970).

evidence in this case and Petitioner has waived any opportunity to develop such evidence by failing to appeal the protective order. The memo submitted with the plaintiff's trial brief in *Schneider v. Provident Life & Acc. Ins. Co.* (P App 117a) is, at most, ambiguous as to whether or not it proves any conflict. But again, the memo concerns a different insurer and does not relate to Respondent or to this claim. At most, it shows that an insurer in that case might have had a conflict in connection with that claim. Again, the Seventh Circuit would consider such specific evidence if it were related to Petitioner's claim. Ironically, *Schneider* was not even an ERISA case and it is not clear whether the memo was even admitted into evidence. At any rate, that case was tried to a jury under California state law and the jury rendered a verdict in favor of the insurer.[11] If the memo was admitted into evidence, it obviously did not impress the jury in that case.[12]

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[11] *Schneider v. Provident Life & Acc. Ins. Co.*, Cause No. 97-C-4646 (N.D. Cal.), Dkt. No. 223 (bench trial ruling that "[t]his was not an ERISA plan" and setting the matter for a jury trial); Dkt. No. 244 (judgment that plaintiff's state law claims are not preempted by ERISA); Dkt. No. 245 (judgment entered in accordance with jury verdict in favor of Provident Life & Accident Insurance Company and against plaintiff).

[12] Plaintiff's submission of pleadings from a foreclosure and a replevin action have nothing to do with any conflict of interest on the part of the Respondent, the sole question raised in the Petition. A social security administration decision also does not pertain to any question raised in the Petition. At most, it shows that an administrative law judge found Petitioner to be disabled under the rules that apply in social security proceedings based in part on evidence that was not presented to Respondent and not having the benefit of other evidence that was in Respondent's file. There is nothing in the benefit plan or in ERISA that makes the social security decision binding or even influential in Respondent's decision, particularly when the decision was not submitted to Respondent. This Court's decision in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003) implies as much. *Id.* at 829-34 (discussing the differences between

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In summary, applying the fact-sensitive analysis required in the Seventh Circuit, both the district court and the Seventh Circuit carefully considered any possible bias and both courts concluded that there was substantial evidence demonstrating that Respondent was impartial. Furthermore, by failing to appeal the district court's discovery order, Petitioner waived any opportunity to demonstrate a conflict of interest beyond Respondent's alleged "inherent" conflict based on its dual role as claim administrator and insurer. These facts substantially limit the possibility that a review by this Court will have any impact on application of the abuse of discretion standard in this case or that it will change the result in this matter.

II. THIS IS NOT AN APPROPRIATE CASE FOR RESOLVING HOW A CONFLICT OF INTEREST MIGHT AFFECT THE ABUSE OF DISCRETION STANDARD BECAUSE THE SUBSTANTIVE EVIDENCE WEIGHED HEAVILY IN RESPONDENT'S FAVOR, MAKING IT HIGHLY UNLIKELY THAT LESSENED DEFERENCE WOULD CHANGE THE RESULT IN THIS CASE.

A. Given this Court's Decision in *Firestone*, the Impact of a Conflict of Interest on the Abuse of Discretion Standard Ranges From an Unaltered Abuse of Discretion Standard to Lessened Deference, Short of *De Novo* Review.

In the district court and the Seventh Circuit, Petitioner took the position that any conflict of interest should

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the laws regulating social security and the laws regulating private disability plans and holding that social security's treating physician rule does not apply to private disability plans governed by ERISA).

result in the application of either a *de novo* review standard or a "sliding scale." The former approach applies no deference whereas the latter approach applies different degrees of deference, depending on the magnitude of the conflict. This Court already rejected the former approach in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), when it declined to consider a claim administrator's impartiality as the criterion for determining whether to apply a deferential review standard.

In *Firestone*, the Third Circuit held that whether a claim administrator had a conflict of interest was the determining factor in whether to apply a deferential review standard in ERISA benefit disputes. This Court declined to follow the Third Circuit's reasoning and held that the application of deferential review must depend on the intent of the contracting parties, regardless of how a benefit plan is funded and regardless of whether the fiduciary is conflicted. 489 U.S. at 115. Thus, where "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," courts must apply an abuse of discretion standard of review to fiduciaries' benefit determinations. *Id.* This Court acknowledged that in some cases, discretionary authority might be granted to conflicted claim administrators. In such cases, deferential review would still apply and the conflict would be "weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (citation omitted).

In summary, this Court has already determined that, regardless of any conflict on the part of the claim administrator, courts will enforce discretionary authority in plan documents, and will only take the conflict into account as a factor when applying the abuse of discretion standard.

As a practical matter, then, the potential impact that a conflict of interest may have on the abuse of discretion standard may range from no impact (i.e. full deference) to lessened deference, short of *de novo* review.

B. Even if this Court Holds that Less Deference Applies when an Insurer Decides ERISA Claims, it is Highly Unlikely that the Result would Change in this Case Because the Great Weight of the Record Evidence Would Still Support the Denial.

Assuming *arguendo* that this Court would decide that an "inherent" conflict arises from an insurer's "dual role" and that this type of conflict requires a court to grant less deference under the abuse of discretion standard, the lessened deference would have no impact on the final outcome in this case because of the strength of the medical evidence supporting Respondent's denial. The district court concluded generally that the denial was not only "reasonable" (i.e. not an abuse of discretion or arbitrary and capricious), but that it was "amply supported by extensive medical records." (P App 16a) With respect to Petitioner's orthopedic claim, the district court concluded that the "medical evidence was in near unanimous support of the conclusion that plaintiff was not disabled." Similarly, with respect to Petitioner's memory loss claim, the district court concluded that "the overwhelming weight of the medical evidence – and particularly the conclusions of Dr. Sullivan who was independent and not hired by defendant – suggested that [Petitioner's] complaints were exaggerated and that he did not have significant cognitive impairment." (P App 16a) On appeal, after noting that at least three experts concluded that Petitioner was

"sandbagging," the Seventh Circuit held that Respondent's decision "coincided with the bulk of the medical evidence." (P App 9a) The Seventh Circuit also noted that, while Petitioner's claim was supported by his family doctor and a psychologist who saw Petitioner on a referral from the family doctor, "[o]n the other side of the scale were the opinions of two orthopedic surgeons, two psychologists, a psychiatrist/neurologist, and a registered nurse." (P App 4a) Granted, both courts applied a deferential standard of review in light of Petitioner's failure to produce any evidence of a conflict or bad faith on the part of Respondent, but even a cursory reading of the decisions reveals that neither the district court nor the Seventh Circuit saw the benefit denial as a close call. Even if the courts had applied less deference, the evidence would still be "near unanimous" on the orthopedic claim and "overwhelming" on the cognitive claim, and Respondent's denial would likely be affirmed.

The same result would apply if this Court were to decide that a review standard close to *de novo* should result from the "inherent" conflict. In light of the weight of the record evidence, it is still highly likely that the denial would be upheld. In this respect, Petitioner's argument that summary judgment would not be appropriate because there were some disagreements among the reviewing doctors is not only wrong, but probably irrelevant.

Petitioner's argument is wrong for at least two reasons. First, to the extent that a court applies even minimal deference, the ultimate question of fact is not whether the denial was correct, but whether it was an abuse of discretion. A court can certainly make this determination on summary judgment, even when the record evidence contains disagreements among reviewing doctors and

particularly where the medical evidence in the record is so strong in favor of the denial, as in this case.

Second, Petitioner's argument is also wrong because of the manner in which ERISA benefit disputes are determined. If the district court did not grant summary judgment, it would sit as the fact finder in a bench trial.[13] The substantive evidence at trial would be exactly the same as at summary judgment, i.e., the written administrative record. In fact, Petitioner did not even suggest that the district court should consider other medical evidence not already included in what was an extensive medical record. In this type of proceeding, summary judgment is nothing more than "a vehicle for deciding" whether the denial was correct:

> The review utilized both by this court and the district court in this ERISA case differs in one important aspect from the review in an ordinary summary judgment case . . . [I]n an ERISA case where review is based only on the administrative record before the plan administrator and is an ultimate conclusion as to disability to be drawn from the facts, summary judgment is simply a vehicle for deciding the issue . . . This means the non-moving party is not entitled to the usual inferences in its favor. When there is no dispute over plan interpretation, the use of summary judgment in this way is proper regardless of whether our review of the ERISA decision maker's decision is de novo or deferential.
>
> . . .

[13] In the Seventh Circuit, as in every other circuit that has decided the issue, ERISA benefit disputes are tried to the court and not to a jury. *See, e.g., Mathews v. Sears Pension Plan*, 144 F.3d 461, 466 (7th Cir. 1998).

> Trial is not warranted because the record shows one doctor's diagnosis disagrees with another's, and the fact that judicial review is de novo does not itself entitle a claimant to a trial or to put on new evidence.

Orndorff v. Paul Revere Life Ins. Co., 404 F.3d 510, 517-18 (1st Cir.), *cert. denied*, No. 05-189 (October 11, 2005). In other words, Petitioner's assumption that disagreements among the medical experts would result in a denial of summary judgment if the court applied something close to a *de novo* review standard, is incorrect in an ERISA record review proceeding.

Petitioner's argument that summary judgment would not be appropriate under a less deferential standard is also irrelevant. Even if the district court denied summary judgment and conducted a bench trial on the record, applying minimal deference, the Petitioner would still bear the burden to prove by a preponderance of the evidence that Respondent abused its discretion. There is virtually no chance that Petitioner could ever meet this burden given the district court's conclusions that there was "near unanimous" support for the determination that he was not orthopedically disabled, and "overwhelming" evidence supporting the determination that Petitioner was exaggerating his complaints and was not cognitively disabled.

In summary, this case is not a proper vehicle for certiorari because, no matter what the Court decides regarding the impact of a conflict of interest on the abuse of discretion review standard, the record evidence is such that it is highly likely that Respondent's decision will still be upheld.

CONCLUSION

For the foregoing reasons, Respondent respectfully requests that the petition for writ of certiorari be denied.

Respectfully submitted,

MARY C. NASH
UNITED WISCONSIN
INSURANCE COMPANY
401 W. Michigan Street
Milwaukee, WI 53203
(414) 226-6510

MARK E. SCHMIDTKE*
SCHMIDTKE HOEPPNER
CONSULTANTS LLP
103 East Lincolnway
P.O. Box 2357
Valparaiso, IN 46384
(219) 464-4961

**Counsel of Record*

Counsel for Respondent

October 28, 2005

STATE OF WISCONSIN CIRCUIT COURT POLK COUNTY

Elvis Kobs
65 County Road M
Star Prairie, WI 54026

Plaintiff,

v.

United Wisconsin Insurance Company
P.O. Box 2013
Milwaukee, WI 53201-2013

Defendant.

Other Contracts – 30303

COMPLAINT

(Filed Nov. 28, 2003)

NOW COMES Plaintiff by and through his undersigned attorneys, Novitzke, Gust, Sempf & Whitley, by Jason W Whitley, and for his complaint against defendant above named, states:

1. That the plaintiff, Elvis Kobs, is an adult resident of the State of Wisconsin and has as his residence 65 County Road M, Star Prairie, WI 54026.

2. That the defendant, United Wisconsin Group is an insurance company licensed to do business in the State of Wisconsin and is in the business of providing group benefit insurance to individuals and employers.

3. That on January 4, 2002 and all other times relevant to the causes of action set forth below, the plaintiff, Elvis Kobs, was covered by a policy of insurance issued by United Wisconsin Group.

4. That pursuant to the terms of that policy, Elvis Kobs is provided with disability benefits.

5. That pursuant to the terms of the benefit plan provided by United Wisconsin Group, the plaintiff was

provided short-term disability benefits from January 4, 2002 through July 4, 2002.

6. That after expiration of the short-term disability benefits, the plaintiff requested long-term disability benefits pursuant to the terms of the defendant's plan.

7. That despite meeting the qualifications and criteria for payment of long-term disability benefits, the defendants have denied said benefits to the plaintiff.

8. That the plaintiff has duly and properly complied with all administrative remedies provided by the plan in seeking review of the plans denial of long-term disability benefits.

9. That by and pursuant to the disability plan issued by the defendant, the plaintiff is entitled to receive long-term disability benefits.

10. That the defendant has denied long-term disability benefits to the plaintiff.

11. That such denial is a violation of the terms of the policy and constitutes breach of contract.

12. That since July 4, 2002, the plaintiff, due to injury and/or illness has been unable to perform the material duties of his regular occupation for a period of 180 days since the onset of total disability and through the 24 month period following the elimination period and the plaintiff has been unable to perform any of the material duties of any gainful occupation for which he may reasonably fitted by education, training or experience, due to injury and/or illness.

13. That as a result of said breach, the plaintiff has been damaged in an amount of money equal to his lost benefits, interest, attorney's fees, and other costs associated with this action.

Wherefore, plaintiff demands judgment against the defendant for a specific performance of the contract terms or in the alternative, damages including consequential damages plus costs, attorney's fees, pre-judgment interest and such other relief as the court deems just and equitable.

DATED: 11-26-03 **NOVITZKE GUST, SEMPF & WHITLEY**

/s/ Jason W. Whitley
Jason W. Whitley (ID # 1027052)
Attorneys for Plaintiff
314 Keller Ave No Ste 399
Amery WI 54001
(715) 268-6130

A TWELVE-PERSON JURY IS DEMANDED

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

==========

Elvis Kobs
65 County Road M
Star Prairie, WI 54026 Case No: 04 C 0005 S

Plaintiff,

v.

United Wisconsin Insurance Company
P.O. Box 2013
Milwaukee, WI 53201-2013

Defendant.

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MOTION TO AMEND COMPLAINT

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Plaintiff, Elvis Kobs, by and through his attorneys, Novitzke, Gust, Sempf & Whitley, by Jason W. Whitley, hereby move to amend the plaintiff's complaint.

The basis for the motion is set forth below and in the attached memorandum of law:

1. The plaintiff filed an action in State Court based upon the breach of an employee provided disability policy.

2. The policy was not employer funded.

3. The defendant removed the state action to Federal Court pursuant to ERISA but the defendant is not an ERISA plan or an employer.

4. The defendant's removal may be proper if the subject insurance policy is covered by ERISA; the

removal is not proper if the insurance company defendant is not governed by ERISA.

5. The proper procedure following removal under such circumstances is to recharacterize the state action as falling with ERISA and file an amended complaint pursuant to 29 U.S.C. §1132.

6. The proposed amended complaint is submitted with this motion along with a memorandum of law supporting the motion to amend.

Dated this 15 day of January, 2004.

/s/ Jason W. Whitley

Jason W. Whitley (ID #1027052)
NOVITZKE, GUST, SEMPF & WHITLEY
Attorneys for Plaintiffs
314 Keller Avenue N. Ste. 399
Amery, WI 54001 (715) 268-6130

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

==========

Elvis Kobs
65 County Road M
Star Prairie, WI 54026

Case No: 04 C 0005 S

Plaintiff,

AMENDED COMPLAINT

v.

United Wisconsin Insurance Company
P.O. Box 2013
Milwaukee, WI 53201-2013

Defendant.

==========

Plaintiff, Elvis Kobs, by and through his attorneys, Novitzke, Gust, Sempf & Whitley, by Jason W. Whitley, as and for an amended complaint against the above named defendant, allege as follows:

I. FIRST CAUSE OF ACTION: ERISA CLAIMS

1. The plaintiff, Elvis Kobs, is an adult resident of the State of Wisconsin and has as his residence 65 County Road M, Star Prairie, WI 54026.

2. That the defendant, United Wisconsin Group is an insurance company licensed to do business in the State of Wisconsin and is in the business of providing group benefit insurance to individuals and employers.

3. That upon information and belief, this court may have original jurisdiction over this action pursuant to 28 U.S.C. §1331 as this action may arise out of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §101, et. seq.

4. That upon information and belief, the United State District Court for the Western District of Wisconsin is the proper venue for this action as all parties and all transactions between the parties arise and occur within said district.

5. That on January 4, 2002 and all other times relevant to the causes of action set forth below, the plaintiff, Elvis Kobs, was covered by a policy of insurance issued by United Wisconsi . Group.

6. That pursuant to the terms of that policy, Elvis Kobs was provided with disability benefits.

7. That pursuant to the terms of the benefit plan provided by United Wisconsin Group, the plaintiff was provided short-term disability benefits from January 4, 2002 through July 4, 2002.

8. That after expiration of the short-term disability benefits, the plaintiff requested long-term disability benefits pursuant to the terms of the defendant's plan.

9. That despite meeting the qualifications and criteria for payment of long-term disability benefits, the defendant has denied said benefits to the plaintiff.

10. That the plaintiff has duly and properly complied with all administrative remedies provided by the plan in seeking review of the plans denial of long-term disability benefits.

11. That by and pursuant to the disability plan issued by the defendant, the plaintiff is entitled to receive long-term disability benefits.

12. That the defendant has denied long-term disability benefits to the plaintiff.

13. That such denial is a violation of the terms of the policy and entitles the plaintiff to all rights and remedies provided by the Employee Retirement Income Security Act of 1974.

14. That since July 4, 2002, the plaintiff, due to injury and/or illness has been unable to perform the material duties of his regular occupation for a period of 180 days since the onset of total disability and through the 24 month period following the elimination period and the plaintiff has been unable to perform any of the material duties of any gainful occupation for which he may reasonably fitted by education, training or experience, due to injury and/or illness.

15. That plaintiff brings this action pursuant to 29 U.S.C. §1132 and demands enforcement of the provisions of the insurance plan, actual attorney fees, interest, costs, and any equitable relief necessary to protect the plaintiff's rights under the plan and under ERISA.

16. That pursuant to *Lutheran Medical Center v. Contractors, Laborers, Teamsters, and Engineers Health and Welfare Plan,* and *Rivera v. Benefit Trust Life Insurance Company*, plaintiff seeks prejudgment interest on the total of the delayed benefits.

17. That pursuant to 29 U.S.C. §1132 and *Merideth v. Navistar International Transportation Corporation,* the plaintiff demands payment of actual attorney's fees and costs incurred in the prosecution of this action.

WHEREFORE, plaintiff demands enforcement of the plan, payment of past benefits due, payment of future benefits due, actual attorney fees and costs, payment of interest on past due benefits and judgment against the defendant for all amounts past due with interest, costs

and attorney fees, and equitable relief as necessary to ensure defendant's compliance with the policy and ERISA.

II. Second Cause of Action – State Law Claims

18. That the defendant, United Wisconsin Group is an insurance company licensed to do business in the State of Wisconsin and is in the business of providing group benefit insurance to individuals and employers.

19. That, upon information and belief, the defendant may not be an ERISA plan subject to federal preemption of state law claims.

20. That on January 4, 2002 and all other times relevant to the causes of action set forth below, the plaintiff, Elvis Kobs, was covered by a policy of insurance issued by United Wisconsin Group.

21. That pursuant to the terms of that policy, Elvis Kobs is provided with disability benefits.

22. That pursuant to the terms of the benefit plan provided by United Wisconsin Group, the plaintiff was provided short-term disability benefits from January 4, 2002 through July 4, 2002.

23. That after expiration of the short-term disability benefits, the plaintiff requested long-term disability benefits pursuant to the terms of the defendant's plan.

24. That despite meeting the qualifications and criteria for payment of long-term disability benefits, the defendants have denied said benefits to the plaintiff.

25. That the plaintiff has duly and properly complied with all administrative remedies provided by the plan in seeking review of the plans denial of long-term disability benefits.

26. That by and pursuant to the disability plan issued by the defendant, the plaintiff is entitled to receive long-term disability benefits.

27. That the defendant has denied long-term disability benefits to the plaintiff.

28. That such denial is a violation of the terms of the policy and constitutes breach of contract.

29. That since July 4, 2002, the plaintiff, due to injury and/or illness has been unable to perform the material duties of his regular occupation for a period of 180 days since the onset of total disability and through the 24 month period following the elimination period and the plaintiff has been unable to perform any of the material duties of any gainful occupation for which he may reasonably fitted by education, training or experience, due to injury and/or illness.

30. That as a result of said breach, the plaintiff has been damaged in an amount of money equal to his lost benefits, interest, attorney's fees, and other costs associated with this action.

Wherefore, plaintiff demands judgment against the defendant for a specific performance of the contract terms or in the alternative damages including consequential damages plus costs, attorney's fees, pre-judgment interest and such other relief as the court deems just and equitable.

DATED: 1-15-04

NOVITZKE GUST, SEMPF & WHITLEY

/s/ Jason W. Whitley

Jason W. Whitley (ID # 1027052)
Attorneys for Plaintiff
314 Keller Ave No Ste 399
Amery WI 54001
(715) 268-6130

A TWELVE-PERSON JURY IS DEMANDED

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

Elvis Kobs
65 County Road M
Star Prairie, WI 54026

Plaintiff,

CASE NO: 04-C-0005-S
District Judge John C. Shabaz

United Wisconsin Insurance Company
P.O. Box 2013
Milwaukee, WI 53201-2013

Defendant.

RULE 26(F) JOINT REPORT

Pursuant to the Court's Order and Federal Rule of Procedure 26(f), the parties hereby submit this joint report to facilitate the scheduling and disposition of the above-captioned case:

1. **Potential Mediation or Settlement of Case**

During the 26(f) conference, the parties discussed the possibility of mediation in an effort to settle the case. The parties acknowledged the extent of the medical records at issue herein and the need for review of same. The parties also contemplate briefing summary judgment.

Consequently, should this case not be resolved as a result of summary judgment, the parties have mutually agreed to arrange a mediation. The Court's analysis of the summary judgment motion is likely to affect the parties' evaluation of the merits of this case and their respective

settlement positions. If the parties choose to pursue mediation, they will use a mutually-agreed upon private mediator and share the costs of mediation equally.

2. **Initial Disclosures/Mandatory Discovery**

The parties do not anticipate any changes to the timing, form or requirement for disclosures under Federal Rule of Civil Procedure 26(a).

The Plaintiff has requested a copy of the Defendant's administrative file and a list of persons materially involved in the Defendant's decision to deny long-term disability benefits. The parties have agreed that time need not be spent exchanging copies of medical records as it is likely they are in possession of identical documents. The Defendant has requested a list of the Plaintiff's relevant physicians. The Plaintiff claims he has insufficient information to specifically calculate a damage demand but will phrase his damage estimate in terms of how many months for which be is claiming to be disabled. The Defendant acknowledged that it has reinsurance relative to the claim at issue, and the Plaintiff has requested a copy of the applicable reinsurance agreement.

These disclosures will be made within the time set forth in Federal Rule of Civil Procedure 26(a)(1).

3. **Subjects of Discovery/Completion of Discovery**

Although the parties do not believe that this case requires extensive discovery, the Plaintiff has acknowledged that he wants to conduct the deposition of at least one person material in the Defendant's decision to deny long-term disability benefits to the Plaintiff. The Defendant has

indicated that it will object to such deposition(s) because, under an arbitrary and capricious standard of review, discovery that seeks to examine the thought processes of the decision-makers is precluded [*see Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975 (7th Cir. 1999)]. The parties contemplate completing discovery within ninety (90) days of this report. The parties do not request any change in the discovery limitations imposed by the Federal Rules of Civil Procedure or Local Rules.

4. **Any Other Orders**

The parties do not request any additional orders from the Court at this time.

Dated this 27th day of January, 2004.

NOVITZKE GUST, SEMPF & WHITLEY
Attorneys for the Plaintiff

/s/ Jason W. Whitley
Jason W. Whitley
Wis. Bar. No.: 1027052
314 Keller Avenue N. Ste. 399
Amery WI 54001
(715) 268-6130

UNITED WISCONSIN INSURANCE COMPANY

/s/ Carol L. Dorner
Carol L. Dorner,
Attorney for Defendant
Wis. Bar No.: 1032239
401 West Michigan, WOC10
Milwaukee, WI 53203
(414) 226-6[illegible]0

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ELVIS KOBS,

Plaintiff,

v.

UNITED WISCONSIN INSURANCE COMPANY,

Defendant.

PRELIMINARY PRE-TRIAL CONFERENCE ORDER

04-C-005-S

Preliminary pre-trial conference was held by telephone in the above entitled matter on January 27, 2004, the plaintiff having appeared by Novitzke, Gust, Sempf & Whitley by Jason W. Whitley; defendant by United Wisconsin Group by Carol L. Dorner. Honorable John C. Shabaz, District Judge, presided.

ORDER

IT IS ORDERED that all dispositive motions to be filed during the pendency of this matter, to include motions for summary judgment, shall be accompanied by memoranda of law; opposing party being given 20 calendar days to respond; and the moving party 10 calendar days to reply.

IT IS FURTHER ORDERED that all motions for summary judgment and other dispositive motions shall be served and filed not later than May 1, 2004; motions for summary judgment in accordance with local rule, a copy of which is enclosed.

IT IS FURTHER ORDERED that nondispositive motions, to include procedural motions, may be heard upon five days notice on any Wednesday morning by telephone at 8:00 A.M. or earlier, moving party to initiate the telephone conference to 608-264-5504.

IT IS FURTHER ORDERED that discovery shall be completed and all depositions taken not later than June 10, 2004.

IT IS FURTHER ORDERED that the following discovery materials will not be filed with the Court unless they concern a motion or other matter under consideration by the Court: interrogatories; responses to interrogatories; requests for documents; responses to requests for documents; requests for admission; and responses to requests for admission.

IT IS FURTHER ORDERED that final pre-trial conference is scheduled for June 14, 2004, at 1:00 P.M., pursuant to the provisions of Order Prior to Final Pre-trial Conference, a copy of which is also enclosed.

IT IS FURTHER ORDERED that trial to the Court is scheduled to commence June 25, 2004, at 8:30 A.M.

IT IS FURTHER ORDERED that plaintiff's motion to amend complaint is GRANTED.

Entered this 27th day of January, 2004

BY THE COURT:

/s/ John C. Shabaz
JOHN C. SHABAZ
District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ELVIS KOBS,

Plaintiff,

v.

UNITED WISCONSIN INSURANCE COMPANY,

Defendant.

MEMORANDUM AND ORDER

04-C-005-S

Plaintiff Elvis Kobs commenced this action in Polk County Circuit Court against defendant United Wisconsin Insurance Company alleging breach of contract and seeking benefits allegedly due under a long-term disability policy held by plaintiff's former employer and insured by defendant. Defendant removed pursuant to 28 U.S.C. § 1441(a) arguing that plaintiff's breach of contract claim is preempted by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1132(e)(1). Defendant then moved to dismiss plaintiff's breach of contract cause of action as preempted by ERISA. Plaintiff was granted leave to amend the complaint to state an ERISA claim. The matter is presently before the Court on defendant's motion to dismiss plaintiff's second cause of action for breach of contract as preempted by ERISA. The following facts are taken from plaintiff's amended complaint and the policy, which was referred to in the complaint and provided to the

Court in the form of an attachment to defendant's motion to dismiss.[1]

BACKGROUND

Plaintiff was a participant in a long-term disability group insurance policy issued by defendant to plaintiff's former employer Bernard's Northtown, Inc. Plaintiff received short-term disability benefits from January 4, 2002 through July 4, 2002. After plaintiff's short-term benefits expired, plaintiff requested long-term benefits. Plaintiff's request was denied. Plaintiff exhausted his administrative remedies and brought suit for breach of contract alleging a violation of the terms of the policy.

MEMORANDUM

Defendant moves to dismiss plaintiff's second cause of action for breach of contract arguing that it is preempted by ERISA. Plaintiff states in his brief in opposition to defendant's motion that "defendant may not have a sufficient basis to assert that this case is governed by ERISA because the defendant is not an employer and is not an ERISA plan. The defendant is an insurance company." Citing *Perto v. D.W.G. Corp.*, 148 Wis. 2d 725, 727, 436 N.W.2d 875, 876 (Ct. App. 1989), plaintiff argues:

> The general rule is that ERISA does preempt state claims regarding employer sponsored benefits plans. However, the general rule only applies

[1] Documents that a defendant attaches to a motion to dismiss are properly considered if they are referred to in the plaintiff's complaint and are central to his claim. *Venture Assocs. Corp. v. Zenith Data Systems Corp.*, 987 F.2d 429, 431 (7th Cir. 1993).

> to circumstances where the 'plan' is self-funded and is not insured. If the plan is insured, then state regulation is 'saved' from preemption. ERISA only preempts state law claims if the plan under consideration is an uninsured plan, that is, funded through employer/employee contributions rather than through purchased private insurance.

Plaintiff's argument is unpersuasive.

Plaintiff' alleges a state law cause of action for breach of contract against an insurance company seeking to recover benefits allegedly due under a welfare benefit plan established by plaintiff's former employer through the purchase of insurance from defendant. Such a cause of action is preempted by ERISA. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1986). Accordingly, defendant's motion to dismiss plaintiff's breach of contract cause of action must be granted.

Plaintiff's argument confuses the relationship between ERISA's three main preemption-related provisions: the "preemption clause," the "saving clause," and the "deemer clause." The "preemption clause" provides that if a state law relates to an employee benefit plan, then the state law is preempted unless it is "saved" from preemption by the saving clause. 29 U.S.C. § 1441(a). The "saving clause" excepts (or "saves") from the preemption clause any law that regulates insurance. *Id.* § 1144(b)(2)(A). Finally, the "deemer clause" clarifies that state laws which purport to regulate insurance (and would therefore otherwise fall under the saving clause) may not deem an employee benefit plan to be an insurance company. *Id.* § 1144(b)(2)(B).

The first preemption-related clause is the "preemption clause." The preemption clause applies to any "state law" that "relate[s] to" an "employee benefit plan." *Id.* § 1441(a). ERISA defines the term "state law" broadly to include "all laws, decisions, rules, regulations, or other State action having the effect of law." *Id.* § 1144(c)(1). Accordingly, the U.S. Supreme Court has interpreted the term "state law" to include common law causes of action for breach of contract. *See Pilot Life*, 481 U.S. at 47-48 & n.1. The phrase "relate to" in the preemption clause has a "broad common-sense meaning." *Id.* at 47. A state law "relate[s] to" an employee benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1984) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). Plaintiff's state law cause of action has a connection with the long-term disability group insurance policy because his claim seeks benefits allegedly due under the policy. *See Pilot Life*, 481 U.S. at 47-48. Accordingly, plaintiff's breach of contract cause of action invokes a "state law" that "relates to" the group insurance policy. The inquiry then becomes whether the policy is part of an "employee benefit plan."

An "employee welfare benefit plan" is one type of "employee benefit plan." 29 U.S.C. § 1002(3). An "employee welfare benefit plan" is defined in relevant part as follows:

> any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training

> programs, or day care centers, scholarship funds, or prepaid legal services.

29 U.S.C. § 1002(1).

Defendant's policy is part of an "employee welfare benefit plan." Plaintiff was a participant in a group health insurance policy issued by defendant to plaintiff's former employer Bernard's Northtown, Inc. to provide benefits including long-term disability benefits to participants. "[B]y its express terms, ERISA encompasses welfare plans provided through the purchase of insurance." *Fugarino v. Hartford Life & Accident Ins. Co.*, 969 F.2d 178, 183 (6th Cir. 1992) (construing 29 U.S.C. § 1002(1)). It is "common practice" for employers to establish plans that provide disability benefits to their employees through the purchase of a group health insurance policy from a commercial insurance company. *Id.* (citing *Metro. Life*, 471 U.S. at 727). Accordingly, plaintiff's breach of contract cause of action falls under the preemption clause.

The second preemption-related clause is the "saving clause." The saving clause excepts from the preemption clause any law that "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). For a law to "regulate[] insurance" it must be specifically directed towards the insurance industry. *Pilot Life*, 481 U.S. at 50. For example, in *Rimes v. State Farm Mutual Automobile Insurance Co.*, the Wisconsin Supreme Court held that under Wisconsin subrogation law an insurer cannot share in the recovery from a tortfeasor if the total amount recovered by the insured from the insurer and the wrongdoer does not cover the insured's entire loss. 106 Wis. 2d 263, 316 N.W.2d 348 (1982), *cited in Perto*, 148 Wis. 2d at 727, 436 N.W.2d at 876; *see also*

Paulson v. Allstate Ins. Co., 2003 WI 99, 263 Wis. 2d 520, 665 N.W.2d 744. This equitable principle is specifically directed at the insurance industry. Accordingly, it is saved from preemption as a law that regulates insurance.

To the contrary, a cause of action for breach of contract is not specifically directed towards the insurance industry. *Pilot Life*, 481 U.S. at 50. Accordingly, the saving clause does not apply to plaintiff's breach of contract cause of action. Plaintiff's breach of contract cause of action is preempted by ERISA.

The third preemption-related clause is the "deemer clause." The deemer clause clarifies that state laws which purport to regulate insurance companies may not deem an employee benefit plan to be an insurance company. 29 U.S.C. § 1144(b)(2)(B). In other words, employers who provide disability benefits through plans that are funded through employer/employee contributions rather than through purchased private insurance ("self-funded plans") are exempt from state laws that regulate insurance. *Smith v. Blue Cross & Blue Shield*, 959 F.2d 655, 657 (7th Cir. 1992). In *Perto*, the Court found that the plan could not be "deemed" to be an insurance company because the plan was a self-funded plan. 148 Wis. 2d at 728, 436 N.W.2d at 876. Consequently, the plan was exempt from the subrogation limitation announced in *Rimes*. *Id.*

The deemer clause has no application to plaintiff's breach of contract cause of action. First, plaintiff's breach of contract cause of action does not purport to regulate insurance. Second, defendant is an insurance company; the deemer clause prevents entities that are not insurance companies from being deemed to be insurance companies for state regulatory purposes.

ORDER

IT IS ORDERED that defendant's motion to dismiss plaintiff's state law cause of action is GRANTED.

IT IS FURTHER ORDERED that plaintiff's second cause of action is dismissed without prejudice.

Entered this 2nd day of February, 2004.

BY THE COURT:

/s/ John C. Shabaz
JOHN C. SHABAZ
District Judge

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

Elvis Kobs
65 County Road M
Star Prairie, WI 54026

Plaintiff,

v.

United Wisconsin
Insurance Company
P.O. Box 2013
Milwaukee, WI 53201-2013

Defendant.

Case No: 04-C-0005-S

Assigned Judge:
John C. Shabaz

NOTICE OF MOTION AND MOTION FOR PROTECTIVE ORDER

(Filed Apr. 26, 2004)

TO: Theresa Owens
Clerk of District Court
U.S. Courthouse
120 North Henry St.,
Rm 320
Madison, WI 53703

Jason Whitley
Attorney for Plaintiff
Novitzke, Gust, Sempf
& Whitley
314 Keller Ave No., Ste 399
Amery, WI 54001

PLEASE TAKE NOTICE that Defendant, United Wisconsin Insurance Company ("UWIC"), by and through its attorney, Carol L. Dorner, hereby moves this Court for a Protective Order preventing the Plaintiff from conducting depositions in this matter, because such discovery is beyond that which is permissible under an arbitrary and capricious standard of review under the Employee Retirement Income Security Act of 1974 as amended, 29 U.S.C. § 1001 et seq. ("ERISA"). Further, even if the Court should find that the Plaintiff can obtain discovery beyond the

administrative record in this case, the Court should still find that the Plaintiff did not provide reasonable notice to UWIC of his request to depose a UWIC employee before May 4, 2004.

This motion is supported by UWIC's Brief in Support of its Motion for a Protective Order and Affidavit of Carol L. Dorner submitted herewith and all pleadings on file.

WHEREFORE, Defendant UWIC respectfully requests that the Court enter a Protective Order precluding Plaintiff from conducting discovery depositions in this case.

Dated this 23rd day of April, 2004.

UNITED WISCONSIN INSURANCE COMPANY

By: /s/ Carol L. Dorner
Carol L. Dorner
State Bar. No.: 1032239

P.O. ADDRESS
401 West Michigan Street, WOC10
Milwaukee, WI 53203-2804
Phone: (414) 226-6930
Facsimile: (414) 226-6229

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

Elvis Kobs
65 County Road M
Star Prairie, WI 54026

Plaintiff,

Case No: 04-C-0005-S

v.

Assigned Judge:
John C. Shabaz

United Wisconsin
Insurance Company
P.O. Box 2013
Milwaukee, WI 53201-2013

Defendant.

BRIEF IN SUPPORT OF DEFENDANT'S MOTION FOR PROTECTIVE ORDER

(Filed Apr. 26, 2004)

INTRODUCTION

The Plaintiff originally commenced this action in Polk County Circuit Court in November 2003. Defendant United Wisconsin Insurance Company ("UWIC") removed the case to this Court on the basis of preemption of the Plaintiff's state law causes of action by the Employee Retirement Income Security Act of 1974 ("ERISA").

UWIC filed a motion for summary judgment on or about April 1, 2004. The Plaintiff requested and was granted an Enlargement of Time in which to file a response brief, in part, because the Plaintiff's counsel, Mr. Whitley, seeks to depose a UWIC employee. UWIC objects to such deposition because under an arbitrary and capricious standard of review of a benefit determination under

an ERISA plan, the scope of discovery is limited to the administrative record. Pursuant to F.R.C.P. 26(c)(1) UWIC moves for a protective order preventing the Plaintiff from conducting depositions and limiting discovery in this matter to the administrative record. Further, even if the Court finds that the Plaintiff can obtain discovery beyond the administrative record in this matter, it should still deny the Plaintiff's request for a deposition to be scheduled prior to May 4, 2004, because UWIC has not received reasonable notice.

FACTS

The background facts in this case have been previously set forth in the parties' briefs on file with the Court. Further, it has been established in the Court's Memorandum and Order of February 2, 2004, that the group disability insurance policy at issue in this matter qualifies as an "employee welfare benefit plan" as that term is defined in ERISA.

During the parties' 26(f) conference on January 20, 2004, the Plaintiff's counsel, Mr. Whitley, indicated that he would request the deposition of a UWIC employee subsequent to his receiving UWIC's administrative file. Dorner Aff. ¶ 4. At that time, UWIC's counsel advised Mr. Whitley that UWIC would object to depositions because discovery in this case is limited to the administrative file under ERISA's arbitrary and capricious standard. Dorner Aff. ¶ 4. This was documented in the parties' Joint 26(f) Report dated January 27, 2004, and on file with the Court. Dorner Aff. ¶ 4.

UWIC provided the Plaintiff with its initial disclosures on February 2, 2004. Dorner Aff. ¶ 6. On February

19, 2004, UWIC provided the Plaintiff with its answer to the Plaintiff's Demand to Produce and documents from UWIC's administrative file, with the exception of medical records which Mr. Whitley had not requested. Dorner Aff. 7. Based on these disclosures, the Plaintiff would have been aware that Constance DuBose was a UWIC employee involved in the review of the Plaintiff's claims. Dorner Aff. ¶¶ 6, 7.

It was not until April 22, 2004, that Mr. Whitley's office contacted UWIC via telephone to request that the deposition of Constance DuBose be scheduled prior to May 4, 2004. Dorner Aff. ¶ 8. No written notice of deposition has yet been received by UWIC. Dorner Aff. ¶ 8.

Additional facts will be set forth in the Argument section as necessary.

ARGUMENT

I. UNDER THE ARBITRARY AND CAPRICIOUS STANDARD OF REVIEW THE PLAINTIFF IS NOT ENTITLED TO DISCOVERY BEYOND THE ADMINISTRATIVE RECORD; THEREFORE, THE DEPOSITION SOUGHT BY THE PLAINTIFF IS NOT A VALID GROUND OF INQUIRY IN THIS MATTER.

A. An Arbitrary And Capricious Standard Of Review Applies To This Court's Review Of UWIC's Benefit Denial.

The standard for judicial review of benefit determinations under ERISA plans depends primarily upon the language of the employee welfare benefit plan at issue. The Supreme Court, the Seventh Circuit and this Court have all held that if the plan's language confers discretionary

authority upon the plan administrator or fiduciary to determine eligibility for benefits or to construe the terms of the plan, then the courts will apply the deferential arbitrary and capricious standard of review. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L. Ed. 2d 80 (1989); *Wilczynski v. Kemper Nat'l Ins. Co.*, 178 F.3d 934, 935 (7th Cir. 1999); *Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810, 814 (W.D. Wis. 1997). Where the plan's language fails to confer discretionary authority, the courts will apply a *de novo* standard. *Id.*

"No magic words are required to confer discretion on an administrator." *Chojnacki*, 108 F.3d at 815; *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331 (7th Cir. 2000). However, the Seventh Circuit has drafted the following "safe harbor" language, the use of which shall trigger the arbitrary and capricious standard of review:

> Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them.

Herzberger, 205 F.3d at 331.

In the case at bar, the employee welfare benefit plan (the "Plan") that was maintained by the Plaintiff's former employer, Bernard's Northtown, Inc. ("Bernard's Northtown"), and insured by UWIC and under which the Plaintiff seeks benefits contains the following provision:

> **BENEFIT DETERMINATION**
>
> Benefits under this policy will be paid only if United Wisconsin Insurance Company decides *in its discretion* that the Insured is entitled to them.

UWIC's Brief in Support of its Motion to Dismiss, Ex. A, p. 6 (emphasis added). This Plan language clearly parrots

that of the Seventh Circuit's "safe harbor" and expressly confers discretionary authority concerning benefit determinations to UWIC. Thus, the arbitrary and capricious standard of review applies to this Court's review of UWIC's denial of benefits.

B. Under The Arbitrary And Capricious Standard Of Review, Discovery Is Limited To The Administrative Record.

Under the highly deferential arbitrary and capricious standard of review, consideration of evidence by the court is limited only to that which was submitted to the plan's administrator at the time the claims decision was rendered. *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975 (7th Cir. 1999) (finding that the district court erred in allowing discovery beyond the administrative record); *Winters v. UNUM Life Ins. Co. of Am.*, 232 F.Supp.2d 918, 927 (W.D. Wis. 2002). "Deferential review of an administrative decision means review on the administrative record." *Perlman*, 195 F.3d at 981-982. Inquiry into the thought processes of the administrator's staff, the training of those who considered the plaintiff's claims "and in general who said what to whom within [the administrator]" goes beyond that which is allowed under a deferential review. *Id.* The Seventh Circuit has not allowed parties to take discovery into the mental processes of the administrator's personnel in cases where an arbitrary and capricious standard governed. *Id.* at 982. Moreover, if a party desires to add to the administrative record evidence that the plan administrator has not reviewed in relation to the benefit determination, the appropriate remedy is for the court to remand the case to the administrator for another determination. *Wardle v.*

Central States Southeast & Southwest Areas Pension Fund, 627 F.2d 820, 824 (7th Cir. 1980), *cert. denied*, 101 S.Ct. 922 (1981).

On February 2, 2004, UWIC provided the Plaintiff with its initial disclosures pursuant to F.R.C.P. 26(a)(1). Dorner Aff. ¶ 6. On February 19, 2004, UWIC provided the Plaintiff with a copy of the administrative record pertinent to the Plaintiff's claims, other than medical records for which the Mr. Whitley has made no request. Dorner Aff. ¶¶ 3, 7. UWIC has also answered the Plaintiff's related Demand to Produce based on the administrative record. Dorner Aff. ¶ 7. As a result of these disclosures, the Plaintiff would have been aware of the involvement of UWIC's employee Constance DuBose in the review of the Plaintiff's claims. Dorner Aff. ¶ 7.

On April 22, 2004, Mr. Whitley's office contacted UWIC telephonically to schedule the deposition Constance DuBose prior to May 4, 2004. Dorner Aff. ¶ 8. However, the mental processes of Ms. DuBose or any other UWIC employee involved in the review of the Plaintiff's claims are not legitimate grounds of inquiry under the applicable arbitrary and capricious standard of review. Clearly, discovery through a deposition would examine the thought processes of the deponent and would expand the scope of discovery well beyond the administrative record.

Therefore, an Order prohibiting the Plaintiff from conducting such deposition is warranted. Further, if the Plaintiff wishes to add to the administrative record, this Court should remand this case to UWIC for another review and determination concerning the Plaintiff's claims.

II. EVEN IF THE COURT WOULD DETERMINE THAT A DEPOSITION IS WARRANTED, UWIC HAS NOT HAD REASONABLE NOTICE SUCH THAT IT SHOULD BE UNDULY BURDENED TO SCHEDULE SUCH DEPOSITION PRIOR TO MAY 4, 2004.

Even if the Court should determine that the Plaintiff can obtain discovery beyond the administrative record in this case, UWIC is still entitled to reasonable notice of depositions pursuant to F.R.C.P. 30(b)(1). The Plaintiff has failed to provide reasonable notice of his verbal request to depose Constance DuBose before May 4, 2004.

In this case, UWIC put both the Plaintiff and the Court on notice of its position that it would object to depositions in this matter as early as January 20, 2004, during the parties' 26(f) conference and in the parties' Joint Rule 26(f) Report dated January 27, 2004. Dorner Aff. ¶ 4. This was also documented in UWIC's Preliminary Pretrial Conference Report dated January 21, 2004. Dorner Aff. ¶ 5.

Mr. Whitley was provided with UWIC's initial disclosures on or about February 2, 2004, which included the name of Constance DuBose. Dorner Aff. ¶ 6. Further, Mr. Whitley would have been aware of Ms. DuBose's review of the Plaintiff's claims as found within the administrative file documents produced by UWIC on February 19, 2004. Dorner Aff. ¶ 7. The fact that Mr. Whitley's office did not request the deposition of Ms. DuBose until April 22, 2004, and then further requested that such deposition be scheduled prior to May 4, 2004, is not reasonable notice to UWIC.

The Plaintiff has been aware for three months that UWIC would object to depositions in this matter. The

Plaintiff has further been aware for two months of Ms. DuBose's involvement in the review of the Plaintiff's claims at issue. Therefore, it is unreasonable for a deposition request be made upon UWIC and its employee with less than two weeks' notice. Further, because I am in-house counsel and currently handling the workload of another attorney who is on a medical leave, it would be unreasonably burdensome to my schedule to arrange for a deposition within the next six working days. Dorner Aff. ¶ 2.

CONCLUSION

For all of the reasons set forth above, the Court should grant Defendant's Motion and enter a Protective Order prohibiting the Plaintiff from conducting depositions and limiting discovery in this case to the administrative record. Even if the Court should find that discovery can be obtained by the Plaintiff beyond the administrative record, the Court should still find that the Plaintiff's request to depose Constance DuBose prior to May 4, 2004, is unduly burdensome to UWIC and is not based upon reasonable notice.

Dated this 23rd day of April, 2004.

UNITED WISCONSIN
INSURANCE COMPANY

By: /s/ Carol L. Dorner
Carol L. Dorner
State Bar. No.: 1032239

P.O. ADDRESS
401 West Michigan Street, C-10
Milwaukee, WI 53203
Phone: (414) 226-6930
Facsimile: (414) 226-6229

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

ELVIS KOBS, **Civil 04-C-0005-S**

Plaintiff,

v.

UNITED WISCONSIN INSURANCE COMPANY

Defendant.

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS SECOND MOTION TO CONTINUE DEFENDANT'S SUMMARY JUDGMENT MOTION FOR ENLARGEMENT OF TIME TO REPLY TO DEFENDANT'S SUMMARY JUDGMENT MOTION and TO COMPEL DEPOSITION DISCOVERY and in OPPOSITION TO DEFENDANTS MOTION FOR PROTECTION

The Defendant, Elvis Kobs, through his attorneys, Novitzke, Gust, Sempf & Whitley, by Jason W. Whitley, have moved the court for the following relief:

1. Continuance of the Defendant's Summary Judgment Motion Hearing and Enlargement of time in which to respond to Defendant's Motion for Summary Judgment and for an order to compel the Defendant to produce witnesses for depositions.

The plaintiff files this memorandum of law in support of his requests.

The Defendant has filed a Motion for Summary Judgment requesting certain relief including total dismissal of Plaintiff's claims.

Pursuant to FRCP 56(f) a Court may issue an order for a continuance to permit the party opposing summary judgment to obtain depositions or allow further discovery in order that the opposing party may effectively oppose the moving the party.

In the represent matter, the Plaintiff cannot effectively oppose the Defendant's Motion for Summary Judgment until the Plaintiff has answers to certain essential facts regarding the character and nature of the Defendant's insurance policy, as well as the underlying facts regarding the Defendant's handling of the Plaintiff's application for disability insurance benefits. These facts are essential in determining whether the Defendant is entitled to protections afforded by the Employee Retirement Income Security Act (ERISA) of 1975.

The Plaintiff needs to learn what information was available to the Defendant at the time Plaintiff made his request for insurance disability benefits and also the manner in which the Defendant handled and processed that claim subject to the terms and provisions of its own policy. In addition, the Plaintiff needs to know whether the Defendant, in denying the Plaintiff's claims for insurance benefits, acted in a dual capacity as both insurer of the Plaintiff and the Administrator of the plan or the policy covering such a plan. This information is necessary to determine the proper standard of review because the defendant is claiming that its coverage decisions are subject to the strict arbitrary and capricious standard which properly only applies to plan administrators. Here,

the defendant does not appear to be an not an administrator but rather a mere insurance company.

Pursuant to *Firestone Tire and Rubber Co. v Bruke,* 489 U.S. 101, 115 (1989), if an insurance company acts in a dual capacity which places that insurer in a perpetual conflict as to both the insurer and interpreter of the plan, then the proper standard of review is de novo. *Id.* In the present matter is appears from the administrative record that and defendant's position on summary judgment that the defendant has acted in a dual capacity thus requiring a de novo standard of review. However, additional discovery by way of deposition needs to be conducted.

At the present time, the Plaintiff is unable to determine whether United Wisconsin acts as the insurer, interpreter, and the administrator of Mr. Kob's insurance policy and therefore, it is unable to determine the correct standard of review.

This is an important matter because the Defendant's Summary Judgment Motion requests a determination that the standard of review is arbitrary and capricious. It is impossible for Plaintiff to respond to the Defendant's Motion in that regard unless the Plaintiff can determine the various procedures followed by United Wisconsin Company in reviewing and refusing Mr. Kobs's insurance claim.

The proper standard of review is of great importance in ascertaining whether an insurer wrongfully denied benefits under a benefits policy. Plaintiff must be able to conduct necessary discovery before he can effectively proceed on those issues.

Therefore, because the Plaintiff cannot properly defend against Defendant's Motion for Summary Judgment without obtaining certain necessary discovery material.

Dated this 5th day of May, 2004.

/s/ Jason W. Whitley
Jason W. Whitley, #1027052
NOVITZKE, GUST, SEMPF
& WHITLEY
Attorneys for Plaintiff
314 Keller Avenue North,
Suite 399
Amery, Wisconsin 54001
715-268-6130

UNIVERSITY OF MINNESOTA

Twin Cities Campus

Mayo Mail Code 295
420 Delaware Street, Southeast
Minneapolis, MN 55455
Office: 612-625-9900
Fax: 612-625-7950
www.neurology.umn.edu

Department of Neurology
Medical School

SUMMARY OF NEUROPSYCHOLOGICAL EVALUATION

Patient's Name:	**KOBS,** Elvis Kevin
Medical Record #:	**0050132702**
Date of Evaluation:	August 22, 2002
Referring Physician:	Neal Melby, M.D. New Richmond Clinic New Richmond, WI

I. REASON FOR REFERRAL

Mr. Kobs, a 51-year-old, right-handed man, was evaluated for documentation of his cognitive baseline in the setting of his complaints about his memory. Mr. Kobs suffered what sounded like a mild closed head injury in 1999, followed by a fall from a roof onto his left side which spared his head this past January. Mr. Kobs, according to office notes from Dr. Melby, began complaining about memory loss after the fall from the roof. He subsequently was referred to a neurologist, John Floberg, M.D., for follow-up of his complaints. According to Dr. Melby's, not Dr. Floberg's notes, Dr. Floberg did an MRI scan of his head and found some sort of abnormality in the right

frontal lobe that he reportedly thought was incidental, e.g., not related to Mr. Kobs's complaints about his memory. According to the same set of notes, Dr. Floberg thought that Mr. Kobs's memory complaints were due at least in part to depression, although according to the notes, Mr. Kobs disagreed with Dr. Floberg, since he thought his memory problems were worsening. Mrs. Kobs reported to this examiner that her husband's short-term memory loss has become progressively worse since 1999 when he hit his head at work. Mr. Kobs reported that he is in the process of applying for long-term disability after being fired from his job in May of this year. He has hired an attorney to aid him in establishing disability status.

II. RELEVANT HISTORY

History of Presenting Complaint: Mr. Kobs was accompanied to the evaluation by his wife Donna, who often interjected details about Mr. Kobs's history. Mr. Kobs reported that in 1999 he hit his head on the corner of a steel filing cabinet at work. He reportedly opened a door inward into a room to talk to someone in the room, leaned in forcefully with his head after closing the door and reopening it because the person was still speaking to him, then struck the left front of his head on a corner of the cabinet. He reportedly held onto the doorknob because he went right to his knees. He immediately experienced dizziness and headaches, went to the bathroom and threw up, but was not knocked unconscious. He reported that the skin on his fore head broke where he had hit it on the cabinet, it bled, and the area eventually turned black and blue. He did not seek any medical attention the day he hit his head, reportedly because he had to work. After working the entire day the next day, he went to the hospital because

his head was hurting so badly and he was sick to his stomach. He reportedly did not remember what was done to work up his complaints. He could not recall having been given pain medication. However, he started going to a chiropractor for the headaches; the treatment brought only temporary relief.

Regarding the memory loss he reportedly experienced after he hit his head, he reported that at work his general manager kept giving him sly (Mr. Kobs used the word "slide") comments that he, the manager, could match Mr. Kobs's brain any day. Mr. Kobs reported that he did not understand where his general manager was "coming from," since he has reportedly had twenty-six years of experience as a business manager, and "never, ever made any mistakes in [my] life as far as [my] work." Mr. Kobs reported that subsequent to the incident, he started having to take a lot of notes at work. He reportedly used to deal with twenty or more banking institutions and could remember their fax and phone numbers, but started having to look the numbers up in his computer. He reportedly recently went to town and could not remember his home phone number, so he went to his daughter's to ask her. He commented, "I want to know why this is happening." Mrs. Kobs reported that her husband's short-term memory is getting worse and worse, but his long-term memory is fine. When Mr. Kobs was asked about his ability to pay attention, he denied any problems, but Mrs. Kobs reported that he "almost just doesn't get it." Mrs. Kobs also reported that she has to write out the checks because "he forgets." Mr. Kobs, however, reported that he has cashed in his 401K and brought his first and second mortgages up to date.

In January of this year, Mr. Kobs was taking Christmas decorations down from the roof of his granddaughter's house while standing on one side of the peak when he lost his balance and fell. Mrs. Kobs reported that he fell backward off of a ladder, but Mr. Kobs implied that he was standing on the peak of the roof when he lost his balance and fell. In any case, he reportedly fell thirty-five feet onto concrete and landed on his left side. He reportedly chipped his rotator cuff on the left, injured his left knee, injured his left wrist and fractured his left hand. He denied that he hit his head. Reportedly, he was hospitalized for a long time after the fall, and he was kept stationary because of the fear of blood clots forming in his leg. He had no surgery after the fall, but according to the notes from Dr. Melby, he complained about the knee's not being able to support his weight. He was also complaining of neck and low back pain. According to notes from the orthopedic surgeon, Thomas V. Reiser, M.D., of Midwest Spine & Orthopaedics, MRI scan of his lumbar spine done in April, 2002 revealed degenerative disc disease at L3 through L5 without herniation, mild stenosis at L3-L4 and L4-L5, and a small central herniation of "questionable significance" at L5-S1. MRI scan of the cervical spine in March, 2002, revealed mild degenerative disc disease at C3-C4 and herniation at C5-C6, according to notes from Dr. Reiser. Dr. Reiser commented that he thought the pain he was experiencing was due to an aggravation of pre-existing disc disease.

According to Dr. Melby's notes, Mr. Kobs sustained a torn horn of the meniscus medial compartment in a fall, which fall is unclear since he had fallen at work and he fell from the roof. This tear was subsequent to arthroscopy and

meniscectomy done in the fall of 2001 because of pre-existing complaints about his knee. After the surgery, he continued to complain that his knee felt unstable. He was referred back to Dr. Engelking, the surgeon, told to continue with his knee brace, and given Paxil and analgesics. Notes from Dr. Engelking were not available, but apparently after all of this, he fell from the roof. Subsequent to the fall, Mr. Kobs experienced chronic edema in that leg and examination for deep vein thrombosis was undertaken by Dr. Melby, with negative results.

Of interest were the notes from Dr. Reiser dated December 28, 1999. Mr. Kobs was reporting "symptoms of neck pain, headaches, upper back pain and bilateral shoulder/arm paint to the elbow, with numbness and tingling in his hands." Mr. Kobs reported to Dr. Reiser that three to four months prior to the date of the visit, he was sitting at his desk and bent over to get into a lower drawer when he immediately felt low back pain. He received films of his lumbar spine and was prescribed pain medication. Mr. Kobs also reported to Dr. Reiser that in September of 1999, he "ran into a steel cabinet at work and sustained a bruise to the head. He sought treatment at Holy Family Hospital ER, for neck pain, nausea, and headaches." He was prescribed pain medication. He then continued treatment with Dr. Melby for neck pain, upper back pain, and radiating low back pain. His right leg reportedly was giving out. After obtaining from Mr. Kobs localization of the pain, description of the pain, pain rating, aggravating factors, alleviating factors, and factors affecting his sleep, Dr. Reiser obtained the history from the patient that a year ago, he slipped on the ice at work. He immediately felt neck pain and low back pain, sought treatment with

Dr. Melby for three to four months, then reportedly experienced a complete recovery. He also reportedly told Dr. Reiser that after the head injury at work in September of 1999, he continued treatment with Dr. Melby for his neck pain, upper back pain, and his low back pain. After more history-taking and a very thorough examination, Dr. Reiser concluded that Mr. Kobs had "multiple level degenerative disc disease with mechanical lower back pain regarding the lumbar spine." He also "suspect[ed] degenerative disc disease of the cervical spine and chronic mechanical pain." Dr. Reiser recommended physical therapy.

Psychosocial History: Mr. Kobs reported that he was married before and had three children from his first marriage. Donna, his wife, was also married before with three children from that marriage. Then he and Donna had their own child – for a total of seven children. Mr. Kobs reported that he married his first wife at age sixteen because she was pregnant. They were married in Canada, reportedly the only place where they could get married. Just immediately before or after deciding to leave his first wife, she became pregnant with their third child. He reportedly met Donna and then they had a child – Shantel, age twenty-five. His third son by his first wife was born after Mr. Kobs left. This son is also twenty-five years old. His other two children from his first wife are reportedly thirty-two and twenty-eight. However, if he was married at age sixteen and his wife pregnant at the time, then Mr. Kobs would only be forty-nine.

When asked how he spends his time currently, Mr. Kobs reported that he does his exercises three times per day, uses the whirlpool twice a day, watches the news, walks his circular driveway for exercise, and cruises his pontoon

boat around the lake. He also reported that finances are becoming a source of stress for him right now. He was on short-term disability, then was fired from his job on May 21st of this year. Dr. Melby has deemed him unemployable, both by Mr. Kobs's report and in a note by Dr. Melby. However, long-term disability has been denied him until the insurance company receives the results of this evaluation. He has reportedly not gotten a check for seven or eight months. Mrs. Kobs reportedly had breast cancer and both breasts were removed, is an insulin-dependent diabetic, has been diagnosed with lupus, and is on disability because of the breast cancer. They reported that their children are helping out by doing housework, buying groceries and offering some financial support. Mr. Kobs also reported that his father died of cancer approximately nine years ago, and his mother is still alive and in good health at age 69. She reportedly works at Turtle Lake Casino in the Housekeeping Department.

Developmental, Educational, and Occupational Histories: Mr. Kobs reported that he was born in New Richmond, WI and that his birth was normal. His mother reportedly had him when she was seventeen. At the age of five, he reportedly contracted polio. He was reportedly paralyzed in his legs and on the left side, but could still use his right arm. He was in the hospital for a year at Sister Kenny. Reportedly, doctors told him he would never walk again. His feet are reportedly deformed, according to Mrs. Kobs, but he denied that he has any leg wasting. He also reportedly not only learned to walk again, but took third place in a regional track meet when he was in the third grade.

He denied any developmental delays and added that he was advanced in talking, crawling and walking. He reported

that he started school at the usual time, apparently despite having had polio at age five. He reported that he went to high school in Glenwood, Illinois, and graduated from high school in LaSalle, IL. He then finished two years of college at Boston College. When asked why he quit, he reported that he got into "the car and people business." He reported that he really enjoyed the challenge of financing people who could not otherwise get financing. He reportedly tried to enlist in the Air Force at the age of seventeen or eighteen, but was turned down because of the history of polio.

Mr. Kobs reported that he had worked for eight years at the company which fired him in May. This company – a car dealership – reportedly did not have a leasing and finance department until Mr. Kobs started one and built it up. Prior to this he spent thirteen years at another dealership on the East coast in Massachusetts. He also worked for Anderson Windows in Bayport, MN before the job in Massachusetts. He reported that before he went on short-term disability he was earning an average of eighty thousand dollars or more per year. He reported that long-term disability was supposed to provide payments of about $4,000 per month.

Past Medical History: Mr. Kobs, as noted above, has had surgery on his left knee to repair a torn meniscus that was not related to the fall from the roof. He has also reportedly had gallbladder surgery. He reportedly suffered a heart attack thirteen years ago that damaged the lower left ventricle of his heart. He recently underwent left heart catheterization, angiography, and left ventriculogram because of complaints of chest pain, shortness of breath and radiation to his jaw and right arm in June of this year. He denied any history of stroke or closed head injury in addition to bump on his head from the filing cabinet. As

noted above, there is a history of polio at the age of five. Mr. Kobs had not brought the list of his medications, but between him and Mrs. Kobs, they recalled that he was taking Effexor, Celebrex, Prevacid, Lipitor, Plavix (Mr. Kobs recalled the name of this medication), and Tylenol. According to the report on the heart work-up in June of this year, he was also prescribed nitroglycerin. Mr. Kobs then reported that he is taking Clonazepam for his "crawly legs."

Mr. Kobs denied that he drinks, but reported that he smokes about a pack a day, sometimes more, sometimes less, and that he used to smoke four packs a day. Donna, his wife, also reported that they like to have a Bloody Mary together once in a while. Mr. Kobs reported that the Effexor works very well and he is not depressed. From Dr. Melby's notes it was gleaned that he has a somewhat long-standing history of complaints about depression. However, Mr. Kobs denied that he was depressed before his wife was diagnosed with cancer. After the diagnosis, he reportedly saw both a psychologist and a psychiatrist and was put on Effexor recently. He commented that she, Donna, is his life and that he thought he was going to lose her many times.

At the end of the interview, Mr. Kobs reported that he knows he is not himself because he was very outgoing. He reportedly could give speeches in front of people and know what he was talking about. He became tearful when he said that now he would not make sense. He commented that he is very intelligent but he frustrates his wife because he does not remember. More will be said about affect and personality functioning in the next section.

III. EVALUATION

Intellectual Performance: Mr. Kobs was administered the Wechsler Adult Intelligence Scale-third Edition (WAIS-III)

in order to obtain a measure of overall level of intellectual functioning. On the WAIS-III he performed within the low average range overall. His WAIS-III Full Scale IQ was 80 (low average), his Verbal IQ was 88 (low average), and his pro-rated Performance IQ (based on four rather than five subtests) was 76 (borderline). IQ index scores such as these have a mean of 100 and a standard deviation of 15. Scores ranging from 80-89 are in the low average range, from 90-109 are in the average range, and from 110-119 are in the high average range. Verbal subtests tap performance on a range of verbal knowledge and verbal reasoning tasks and on attention, working memory, and mental arithmetic tasks. Performance subtests tap performance on a range of timed and untimed visual reasoning and visual-motor tasks. Age-adjusted scaled scores are given below, they have a mean of 10 and a standard deviation of 3, with scores of 8 through 12 defining the limits of average.

Wechsler Adult Intelligence Scale-third Edition (WAIS-III)

Verbal	Age-Adjusted Scaled Score	Performance	Age-Adjusted Scaled Score
Vocabulary	7	Picture Completion – not administered	
Similarities	7	Digit Symbol-Coding	5
Arithmetic	7	Block Design	7
Digit Span	8	Matrix Reasoning	9
Information	8	Picture Arrangement	4
Comprehension	11		
(Letter-Number Sequencing)	(8)		

A discussion of these results is integrated into the discussion of performance in each of the cognitive domains below. The number in parentheses refers to a score not averaged into the IQ index score.

Attention/Concentration: Mr. Kobs was fully oriented, except for incorrectly recalling the day of the week. He correctly recalled the names of the current U.S. President, the President who preceded Bush, and the Governor of Minnesota. He could not recall the name of the current Vice President. He attended to all questions and instructions. The level of effort exerted was not thought consistent with what might be expected, given his high level of education (two years of college at an excellent private school in Boston) and all of his reported occupational attainments. In short, Mr. Kobs was not thought to be motivated to perform to the best of his ability, as for example, on IQ testing. This questionable level of effort and involvement in the testing were thought part of larger motivational and personality issues. More will be said about this in the section on Behavior and Personality Functioning, and in the summary of this report. His performance on a task requiring the repetition of series of single digits both forward and backward was in the low average range for age (WAIS-III Digit Span). He correctly repeated one series of six digits forward and two series of four digits backward. On a task requiring the mental solution of orally presented arithmetic word problems under timed conditions, his performance was below average for age (WAIS-III Arithmetic). Performance on a more complex sequencing task requiring him to repeat series of alternating numbers and letters in separate ordered sequences of first numbers followed by letters was within the low average range for age (WAIS-III Letter-Number

Sequencing). Finally, his performance on a spatial working memory task requiring him to learn the associations between four plain white cards in a row and a two-dimensional spatial array of four disks, e.g., which card went with which disk, through trial and error and examiner feedback, was mildly to moderately impaired with respect to the number of errors made, and moderately impaired with respect to the number of trials needed reach the criterion of twelve consecutive correct associations (Petrides Conditional Associative Learning). In fact, Mr. Kobs did not reach that criterion.

Speech/Language: Mr. Kobs spoke grammatically and logically, articulated clearly, and understood all questions and instructions. He occasionally made word substitution errors, such as substituting "slide" for sly. He also occasionally phrased a sentence awkwardly, such as when he said he "financed people" in his business, meaning that he got financing for people unable to get financing to purchase a car. Ideas followed sequentially. Formal knowledge of word meanings was below average for age (WAIS-III Vocabulary). Performance on a verbal reasoning task requiring the generation of higher level verbal abstractions was also below average for age (WAIS-III Similarities). His fund of general knowledge of history, science, religion, geography, and literature was within the low average range for age. (WAIS-III Information). Performance on a common-sense verbal reasoning task requiring social judgement and proverb interpretation, was solidly average for age (WAIS-III Comprehension). Letter fluency, the generation of words to selected letters of the alphabet under timed conditions, was below average to mildly impaired, for age and gender. Confrontational naming was solidly average for age (Boston Naming Test).

Visual-Spatial/Visual-Perceptual Performance: Performance on a visual-spatial reasoning task requiring the construction of two-dimensional block designs from a model was below average for age (Block Design). Performance on a visual information processing and abstract reasoning task requiring him to complete a visual array or finish a sequence using a rule derived from the pattern was also within the average range for age (Matrix Reasoning). Performance on a pictorial sequencing task requiring ordering a series of pictures creating a brief story into a logical, temporally correct sequence was mildly to moderately impaired for age (Picture Arrangement). Mr. Kobs got one item correct on this task. His copy of a complex geometric design was in the range of severely impaired for age (Rey Complex Figure – copy), because Mr. Kobs made a series of minor errors which cost him a number of points. These errors were largely omission errors, including not drawing the fifth of five lines, and omitting small details such as the single line above the small rectangle and the horizontal line within the large triangle which is a continuation of the horizontal midline. He also incorrectly placed the diamond on a line extending out from the tip of the large triangle on the right side of the figure. The small square in the lower left quadrant was drawn wider than the small rectangle inside the central figure.

Visual Memory: His immediate recall and delayed retrieval performances, that is, drawing the complex figure copied earlier from memory after three minutes and thirty minutes, were solidly within the average range with respect to immediate recall, and mildly below average with respect to delayed retrieval, for age (Rey Complex Figure – recall). Delayed recognition requiring the identification and discrimination of parts of the original design from

parts of other designs was mildly impaired for age. The pattern of retrieval vs. recognition (e.g., immediate retrieval, below average delayed retrieval and mildly impaired recognition) was consistent with a "storage" pattern. His performance on an incidental learning task requiring him to draw the symbols of the WAIS-III Digit Symbol task from memory after transcribing them was within the low average range with respect recall of the symbol-number pairings, and below average to mildly impaired with respect to free recall of the symbols (WAIS-III Digit. Symbol – Incidental Learning: Pairing and Free Recall).

Verbal Memory: Performance on a word-list learning and retrieval task requiring recall of words from four categories on each of five learning trials ranged from solidly average to mildly impaired for age and gender (California Verbal Learning Test). Learning over trials ranged from below average on the first trial to mildly impaired on the last trial. His learning curve essentially leveled off after the second trial. The sum total of words recalled was mildly below average. Uncued and cued retrieval after both the presentation of a second list of words (a distraction task) and after a longer delay interval was mildly impaired (two standard deviations below the mean) for age and gender. Delayed recognition of words from the original list was moderately to severely impaired (four standard deviations below the mean for age and gender), while his ability to discriminate list words from other words was mildly impaired. Immediate recall and delayed retrieval of narrative information, e.g., brief paragraphs, were within the average range for age (Wechsler Memory Scale-third edition [WMS-III] Logical Memory I & II). The percentage

of information retained over the delay interval was solidly average for age.

Psychomotor Performance: Speed of performance on a visual scanning and numerical sequencing task was mildly below average for age and gender, with two errors spontaneously corrected (Trail Making Part A). On another visual search task requiring numerical and alphabetical sequencing in alternating order, speed of performance was moderately impaired for age and gender, with one error and no confusion (Trail Making Part B). On still another visual search and symbol substitution task requiring the transcription of symbols under timed conditions, speed of performance was below average to mildly impaired (WAIS-III Digit Symbol).

Motor Performance: Finger-tapping speeds were solidly average with the preferred hand and above average with the non-preferred hand. Upper-extremity, fine, visual-motor speed and control (e.g., grooved peg manipulation) were mildly impaired with the preferred hand and moderately impaired with the non-preferred hand, for age and gender. Mr. Kobs followed directions perfectly on this task.

Executive Functioning: Performance on a nonverbal reasoning and concept formation task requiring the successive generation and utilization of problem-solving principles (color, form, or number) as well as sustaining the use of the principle or changing it in response to examiner feedback ranged from mildly to moderately impaired to below average, for age and level of education (Wisconsin Card Sorting Test). Mr. Kobs demonstrated a tendency to sort cards to some principle other than the most obvious and appropriate ones. Thus, the non-perseverative error rate, or the rate at which he made

errors not pertaining to previously correct principles was in the range of mildly impaired. Otherwise, the numbers and percentages of perseverative errors and perseverative responses were mildly below average. Conceptual level responding, or the number of three or more consecutive correct responses divided by the total number of responses, was also mildly below average. He used each of the three principles ten consecutive times, e.g., the number of categories completed was three, and in the range of mildly impaired. Of some interest was that Mr. Kobs lost set five times, e.g., failed to continue to use the correct problem-solving principle despite having just used it a minimum of five times. This is a highly unusual pattern of performance suggesting extreme distractibility (he did not seem distracted), confusion, or resistance to the task. He also did not appear to benefit from experience with the task, but it is unclear whether his performance truly reflected his ability to understand the task.

Affect, Mood, Behavior and Personality Functioning: Mr. Kobs's affect during the evaluation was not fully congruent with his presentation. In other words, when talking about how he used to be able to stand up in front of people and make sense when he gave speeches, he became tearful, presumably over the fact that he now thinks he would not be able to make any sense in the same situation. However, throughout the evaluation he gave a series of poor – sometimes very poor – performances, yet did not seem at all distressed by these. During a break from the testing he was urged to do his best, in response to his question about how he was doing. He reported that he thought he was doing well, when he clearly was not. At the same time, he expressed distress that he can no longer do what he used to be able to do. If he were clearly upset about these

hypothesized changes, then it is unclear why he was not bothered more by his own poor performance during this evaluation, and completely unclear why he thought he was doing well when he was not, yet reporting that he is a very intelligent person who used to be much better at remembering and giving speeches.

Second, during the Conditional Associative Learning Task, this examiner inadvertently told him a correct response was wrong. He appeared to catch this error immediately, saying, "How can it be wrong," when he appeared otherwise to be having trouble doing the task. There was thus a lack of congruence between his presentation of himself as not being able to master the task, and his catching the examiner's mistake.

In order to clarify discrepancies between his actual performance and his expected level of performance based on achievements in education and occupation, Mr. Kobs was administered the Minnesota Multiphasic Personality Inventory – revised (MMPI-2). Mr. Kobs was not particularly willing to admit to ordinary human flaws. However, he was highly consistent in his responding. In fact, scores on TRIN (true-response inconsistency) and VRIN (variable-response inconsistency) were at the lowest level possible and thus were clearly not suggestive of nay-saying, non-acquiescence, or random responding. Thus, the elevation on the L scale likely reflected moderate "faking good," and the profile may thus not accurately represent the degree of psychological disturbance present.

Mr. Kobs is reporting poor physical health and denying good physical health. In fact, he is preoccupied with his physical functioning. Mr. Kobs responded in a way which suggests that he converts stress and difficulties into

physical complaints, or reacts to stressful events by developing physical complaints, such as headaches, chest pains, weakness or tachycardia. In fact, Mr. Kobs may be exhibiting classic conversion symptoms. Many people with this particular MMPI-2 profile develop somatic symptoms centered around headaches or abdominal pain. In fact, Mr. Kobs is reporting multiple physical complaints, such as headaches, dizziness and problems with balance. Symptoms appear very suddenly and may abate quickly as well. Although physical complaints may be the primary problems reported, he may also feel dysphoric and worried, lacking in energy and having difficulty concentrating and paying attention. He may feel that life is empty. He may appear apathetic. He is conventional and takes a cautious approach to life. At the same time, he is uninsightful about his own motives and feelings, resists psychological explanations or interpretations of his problems, and denies or represses feelings and psychological problems. He may respond well to direct advice or suggestion, if defenses (e.g., physical symptoms) are not challenged or threatened.

Mr. Kobs may also seek and expect attention and a lot of affection from others, and then use indirect or manipulative means to get them. He may be indirect interpersonally and not likely to express anger and resentment openly. He may be passive-dependent in relationships. He is sociable and wants to be liked. He may be somewhat superficial in interpersonal relationships. He appears to have a good marital relationship, and, while he was still working, probably had good work adjustment. However, because he produced a "faking good" profile to a moderate degree, there may be problems with adjustment and functioning which he did not report.

Overall, Mr. Kobs is not a good candidate for insight-oriented psychotherapy. However, supportive counseling, especially given the potential seriousness of his wife's condition, is recommended.

IV. COMMENT

Mr. Kobs, a 51-year-old, right-handed man, was evaluated for documentation of his cognitive baseline status in the setting of concerns about his memory. Mr. Kobs reported to his primary care physician that he was having progressive difficulty with his memory after he fell 35 feet, reportedly, from a roof while taking down Christmas decorations. He reported to this examiner that he landed on his left side, did not hit his head, fractured his left hand/thumb, and injured his left wrist, leg and shoulder. However, during this evaluation, he reported to this examiner that the source of his memory problems was a bruise to his head in 1999 when he leaned into a room and struck the left part of his forehead on the corner of a steel filing cabinet.

Neuropsychologically, Mr. Kobs's performance needs to be put into the context of the seriousness of the head injury suffered in 1999, since that is the event from which he and his wife both are dating the changes and deterioration in his memory. First of all, in that incident, he did not lose consciousness. In fact, he did not seek medical attention until the end of the next day, after a full day's work. It is unclear how he was able to function that day if he had a head injury the day before serious enough to have deteriorating effects on his memory three years later. According to the notes from his primary care physician, he did not complain to this doctor about his memory. Rather, his

complaints centered around pain – pain in his neck, lower back and head, in the form of headaches.

Second, Mr. Kobs was referred to a neurologist, John Floberg, M.D., for investigation of his complaints about his memory after the fall from the roof this year. Dr. Floberg thought that Mr. Kobs's memory complaints were secondary to depression, not to the effects of the fall. Reportedly, an MRI scan of his head, ordered by Dr. Floberg, revealed some sort of abnormality in the right frontal lobe, but what sort of abnormality was completely unclear from Dr. Melby's records, and Dr. Floberg's dictated note was not available for review. However, Dr. Floberg reportedly told Mr. Kobs that the abnormality on the scan was incidental, that is, unrelated to his memory complaints. Dr. Melby noted that Mr. Kobs took exception to Dr. Floberg's interpretation of his memory problems as the result of depression, since Mr. Kobs was insisting that his memory was deteriorating.

Third, the larger issue of Mr. Kobs's continuing presentation to physicians with complaints about pain needs to be noted here. Even before the fall from the roof in fact a couple of years before, Mr. Kobs was reporting pain in his leg. He had a knee operation, which evidently did not resolve his concerns about his knee, since after the surgery he complained that his knee was unstable and likely to give out. He also had chronic low back pain complaints. It is true that Mr. Kobs has degenerative disc disease in his lower back, according to the notes from Dr. Reiser, his orthopedic surgeon. However, even with pain medication and after physical therapy, it appeared that his complaints about pain continued. After further diagnostic work-up in response to his complaints, it was still unclear to Dr.

Reiser, according to his notes, that Mr. Kobs needed surgery even after the fall from the roof.

All of this background information suggested that Mr. Kobs might have presented himself in such a way as to confirm his own view of himself as memory-impaired and brain-injured. However, there are numerous implausible aspects of his performance which raise questions about the effort he exerted throughout this evaluation. First of all, Mr. Kobs's IQ, as measured here, was found to be 80, that is, just barely within the low average range. This is simply not believable. There is no possible way that a head injury of the severity described by Mr. Kobs could have lowered his IQ to this level. Furthermore, there were findings within the IQ testing that were also highly unlikely. Mr. Kobs obtained a score on Vocabulary, which measures knowledge of vocabulary, that was in the low average range. This seems an unusually low score for a man who finished two years of college at Boston College and who used to make speeches and sell cars, a man who reportedly was making an average of $80,000 a year or more and who probably relied on his verbal skills to help him make that kind of money. Furthermore, knowledge of vocabulary is pretty invulnerable to the effects of a mild head injury. That is, one of the least likely effects of a head injury is to lower one's score on Vocabulary. Second, on Block Design, he gave a highly variable performance. He failed a rather simple four-block design because he rotated it out of the proper orientation then rotated it back into the proper orientation after the time limit had expired, yet he quickly completed two nine-block designs that many patients find difficult. This sort of variability in performance, e.g., failing easy items and passing harder ones, is often seen in patients who are depressed or who are not doing their best

on ***all*** items. Third, Mr. Kobs got just one item right on Picture Arrangement – the first item. He then failed the next four items. This is a ***highly unusual*** performance, even for people who are mentally retarded. Mr. Kobs, even given how poorly he performed, is clearly not mentally retarded. Furthermore, it is again completely unbelievable that a person who suffered such a mild superficial injury would experience such devastating effects on his ability to arrange four picture cards in a temporally correct sequence in order to tell a simple story. Fourth, Mrs. Kobs reported that at times, Mr. Kobs is paying such poor attention that he seems not to be "getting it" at all. However, on measures of attention from the IQ test, like Digit Span and Letter-Number Sequencing, he performed within the low average range. Thus, his performance was not typical of someone who is "not getting it." In addition, on the Comprehension subtest from the IQ test, a test of common-sense reasoning and social judgement, Mr. Kobs gave his best performance, a performance solidly within the average range. People who really and truly are not "getting it" would be highly likely to do poorly on this particular test.

With regard to memory functioning, the findings are very interesting. Even though memory functioning was his primary cognitive complaint, there were aspects of memory functioning that were within the average range. His immediate recall and delayed retrieval of brief paragraphs was within the average range for age; the percentage of information retained over the delay interval was solidly average for age. On a very difficult immediate recall task, that is, recalling the Rey figure three minutes after copying it without having first been told that he would be asked to draw it from memory, Mr. Kobs's performance

was solidly average for age. Delayed retrieval, that is, drawing the same figure from memory ***thirty minutes after copying it*** was only mildly below average. It would ordinarily be expected that someone who has genuine memory problems would simply be unable to do this task at all, given how difficult it is. On the simpler task of recognizing parts of the figure that were copied, his performance was worse than on either immediate recall or delayed retrieval, e.g., it was mildly impaired. However, on the recognition task, Mr. Kobs made two Recognition Failure errors, that is, he failed to recognize two parts of the design that he drew on delayed recall. One of those Recognition Failure errors was for a part that he drew almost correctly on immediate recall and only marginally correctly on delayed retrieval because he drew it sloppily. Even so, Recognition Failure errors are highly uncommon in people who have actually sustained brain damage as the result of a head injury. Thus, the interpretation given when there are two of these types of errors done by people who are not brain-damaged is that they are not doing their best on the task. The only task on which he consistently demonstrated mild impairment in all aspects of retrieval was on the California Verbal Learning Test. However, his delayed recognition performance was very unusual on this task. Most people do better on delayed recognition that on delayed retrieval, especially people who have significant memory impairment. In Mr. Kobs's case, his performance on the delayed recognition task was two standard deviations below his delayed retrieval performance, a highly unlikely and unusual discrepancy.

Finally, on the Wisconsin Card Sorting task, a nonverbal reasoning and concept formation task requiring mental flexibility and the ability to profit from feedback, Mr. Kobs

gave another highly unusual performance with respect to the number of set losses. Set losses are the number of times a person stops using the correct problem-solving principle after five correct usages and reverts to a previously correct principle or an unrelated principle. Mr. Kobs lost set five times. This degree of set loss can reflect confusion, or distractibility and problems focusing on the task, or, as is thought in Mr. Kobs's case, resistance to the task. Mr. Kobs seemed to be trying not to make too many correct responses. After he had used each principle three times, he began oscillating back and forth between the two principles that were not in effect, as well as using an unrelated or irrelevant or "non"-principle, e.g., making a random response.

In terms of strengths, he demonstrated good visual memory for the Rey complex figure, solidly average commonsense reasoning and social judgement, and average recall of brief paragraphs.

With respect to personality functioning, as discussed above, Mr. Kobs appears to be having a conversion reaction, e.g., he may be converting psychological problems into physical symptoms, without any awareness of his behavior. Thus, the results of the MMPI-2 suggested that these efforts to make himself look cognitively impaired were not done deliberately, e.g., with the intent to deceive. Mr. Kobs's view of himself as physically unwell and cognitively impaired could have skewed his performance unintentionally in the direction of impairment, when in fact these results, when interpreted in light of all the available information, suggest the opposite – that he is not memory disordered or cognitively impaired. In other words, Mr. Kobs seems to have convinced himself that he has memory impairment, with, it would seem, Mrs. Kobs's unwitting

reinforcement. It was clear that she perceives him as having deteriorating short-term memory, but did not provide a lot of history to substantiate her view.

However, there is undeniable psychological disturbance here. Mr. Kobs was probably under-reporting psychological distress and maladjustment, given his distaste for admitting to normal human weaknesses and character flaws (an elevation to a T score of 70 on the Lie Scale). Thus, it is not clear to what lengths Mr. Kobs would go to reinforce his view of himself as physically unwell and cognitively impaired.

As noted above in the section on Personality Functioning, Mr. Kobs is not insightful about or aware of these behaviors, and he is not likely to benefit from psychotherapy which would offer sophisticated interpretations. However, Mr. Kobs has obviously dealt with a lot of difficult situations attendant upon his wife's diagnosis with breast cancer. She reported having a variety of other serious medical problems. He has some injuries as well as some chronic back problems which are likely to result in the experience of intermittent physical pain. Thus, he is vulnerable to depression and he endorsed some depressive symptomatology, most of it having to do with mental dullness. It is recommended that Mr. Kobs receive some supportive counseling and have the opportunity to discuss sources of stress in his life with a psychologist or social worker trained in helping people who are caregivers. It would appear that Mr. Kobs has in fact on a number of occasions assumed the role of caregiver of his wife. He appears to need additional support.

In summary, the results were not consistent with the presence of memory problems secondary to a closed head

injury. There was in fact no real evidence that he had sustained a closed head injury, e.g., an injury that would have produced cognitive effects. Mr. Kobs's performance was thought to be influenced by his conviction that he is ill and his denial of physical and cognitive well-being. Although an absence of progressive memory loss should be good news, it probably will not be greeted with much enthusiasm. There was evidence of a tendency to convert stress reactions to physical symptoms, and to be unaware of underlying psychological conflicts or concerns. Mr. Kobs was thought to be experiencing more psychological distress than he was willing to acknowledge. It was recommended that he receive supportive counseling. A referral to William Robiner, Ph.D., ABPP, L.P. or Diane Bearman, Ph.D., L.P., health psychologists in the Department of Medicine here at Fairview-University Medical Center, is suggested. This referral would be made by Dr. Melby. Dr. Robiner may be reached at (612) 624-1492, and Dr. Bearman at (612) 624-0933.

With regard to the issue of a return to work, Mr. Kobs passed along a variety of disability forms to be completed. It is this examiner's opinion that he is not cognitively disabled or memory impaired. However, he appears to have some psychological disturbance at this point which would render it difficult for him to be a fully engaged worker, e.g., he sees himself as too sick to work and he is sincerely convinced of this view. Further, this view has been reinforced by his family. He has physical injuries and chronic low back pain. It is therefore also recommended that he be referred to Miles Belgrade, M.D., at Fairview-Riverside, for help in dealing with what appears to be a chronic pain syndrome. Dr. Belgrade may be reached at

(612) 273-5400. Again, Dr. Melby would make this referral if he deemed it appropriate.

The opportunity to address questions regarding Mr. Kobs's cognitive status is appreciated. Thank you for the very interesting referral. If there are questions about this evaluation, please do not hesitate to call (612) 625-7423.

/s/ Mary Sullivan, Ph.D., L.P.
Mary Sullivan, Ph.D., L.P.
Assistant Professor of Neurology

No. 05-394

IN THE

Supreme Court of the United States

ELVIS KOBS,

Petitioner,

v.

UNITED WISCONSIN INSURANCE COMPANY,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

BRIEF FOR LEGAL SERVICES FOR THE ELDERLY AS AMICUS CURIAE SUPPORTING PETITIONER

GARY STONE
Counsel of Record
JONATHAN A. WEISS
LEGAL SERVICES FOR THE ELDERLY
130 West 42nd Street, 17th Floor
New York, New York 10036-7803
(646) 442-3316

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INTEREST OF AMICUS CURIAE

Legal Services for the Elderly (LSE) of New York City, New York, submits this brief amicus curiae, pursuant to Supreme Court Rule 37, in support of the petition for issuance of a writ of certiorari to the United States Court of Appeals for the Seventh Circuit for review of its judgment in *Elvis Kobs v. United Wisconsin Insurance Co.*, 400 F.3d 1036 (7th Cir. 2005). Both Petitioner and Respondent have consented in writing to its submission.[1]

Founded in 1968, LSE is the oldest organization in the country devoted to the provision of legal services to the indigent elderly. LSE specializes in cases involving Social Security and Supplemental Security Income, Medicaid, and disability, pension, and other private employee benefits. LSE assists legal services lawyers by co-counseling in law reform litigation and by providing advice, pleadings, memoranda of law, and briefs amicus curiae.

Like the case at bar, many of LSE's cases have addressed issues concerning adjudicative fairness, including several successful challenges to the procedures used in adjudicating entitlement to employee benefits.[2]

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[1] Pursuant to Sup. Ct. R. 37.6, LSE's counsel of record hereby certifies that this brief was authored in whole by LSE attorneys, and that no individual or entity other than amici curiae LSE has contributed monetarily to the preparation or submission of this brief.

[2] Outside of the employment arena, LSE has been active in challenging procedures that deny the indigent elderly fair and just adjudications of their rights. *See, e.g., Varshavsky v. Perales*, 202 A.D.2d 155, 608 N.Y.S.2d 184 (N.Y. App. Div. 1994) (successfully resisting an attempt by the State of New York to eliminate face-to-face hearings at home for the homebound disabled); *Kendrick v. Sullivan*, 784 F. Supp. 94, 102 (S.D.N.Y. 1992) (granting class certification and denying motion to dismiss in action ultimately settled by reopening of cases decided by biased administrative law judge) ("The right to an impartial adjudication is a basic element of due process. This aspect of

See Bunting v. McCall, 280 A.D.2d 774, 719 N.Y.S.2d 907 (N.Y. App. Div. 2001) (requiring evidentiary hearing to determine whether application for benefits was timely); *Ortiz v. Regan*, 769 F. Supp. 570 (S.D.N.Y 1991) (finding that agency's failure to hold pre-deprivation hearing for termination of benefits violated procedural due process); *Weaver v. New York City Employees' Retirement System*, 717 F. Supp. 1039 (S.D.N.Y. 1990) (holding that officials' actions in terminating benefits violated procedural due process). In recognition of LSE's contributions and expertise in employee benefits, the Administration on Aging (AoA), part of the U.S. Department of Health & Human Services, has awarded several multi-year grants to LSE to provide advice and advocacy to individuals with pension problems throughout New York and New Jersey.

The Seventh Circuit's rule attacked by Petitioner—namely, that "dual-role" insurers[3] are considered to act neutrally in the absence of specific evidence provided by the claimant showing a conflict of interest—is substantially the same as that followed by the Second Circuit and the district courts subject to its authority. These courts are the principal forums in which LSE litigates cases involving ERISA-governed benefit plans. Ten years ago, when the Second Circuit first announced its highly deferential standard in *Pagan v. NYNEX Pension Plan*, 52 F.3d 438 (2d Cir. 1995), LSE immediately understood its potential significance and appeared as *amicus curiae* in support of an unsuccessful motion for reconsideration.

Unfortunately, in the ten years since *Pagan* was decided, LSE's fears have been confirmed, as the opinion has become one of the most frequently cited employee

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due process applies equally in an administrative setting as it does in a judicial forum.").

[3] As noted by Petitioner, a "dual-role" insurer both makes benefits eligibility determinations and is financially responsible for paying any benefits it grants. Pet. 2.

benefits rulings within the Second Circuit, almost always being invoked to the detriment of elderly or disabled plaintiffs. So sweeping has been its application, and so impregnable has been the barrier to benefits created by *Pagan*, that in many instances, LSE's clients have been denied benefits that likely would have been awarded if a less deferential standard of review applied, resulting in great hardship. In a recent, still-pending case in which LSE sought *de novo* review on the basis of a conflict of interest, the district court, following *Pagan*, still insisted on applying the highly deferential arbitrary and capricious standard. *Nerys v. Building Service 32B-J Health Fund*, 2004 WL 2210256 (S.D.N.Y. Sept. 29, 2004). In view of LSE's present and on-going representation, it has a significant interest in the resolution of the questions presented in the petition for certiorari.

SUMMARY OF ARGUMENT

Amicus curiae LSE agrees with the reasons set forth by Petitioner as to why the writ should be granted and the questions presented resolved on the merits. In addition, drawing on its years of experience representing the indigent elderly in cases involving conflicted insurers, LSE points to several concerns that it believes give added urgency to the need for this Court to resolve the issues raised in the petition for certiorari.

Leaving intact the rule used to deny Petitioner's claim will perpetuate the present untenable situation in which participants and beneficiaries of ERISA-governed plans will continue to be denied benefits without ever having had the opportunity to have a "full and fair" adjudication of their claims. 29 U.S.C. § 1133 ("[E]very employee benefit plan . . . shall afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim."); 29 C.F.R.

2560.503-1(h)(1) ("Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have . . . a full and fair review of the claim and the adverse benefit determination."). ERISA's statutory language and policy rationales mandate that claims denials should be reviewed by either (i) an adjudicator with no conflict of interest, or (ii) a court that does not give deference to a decision made by an adjudicator that has a conflict of interest. Any other rule would subvert Congress's principal aim in enacting ERISA: ensuring that employees and their beneficiaries receive all the benefits for which ERISA-governed plans make them eligible. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) ("ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits.").

At the core of the approach according deference to conflicted ERISA "administrators" is the false premise that private insurance companies should be treated with the deference afforded public administrative agencies, rather than, as Congress intended, with the level of review appropriate to decisions of trustees. The ironic and certainly unintended result is that ERISA acts to shield, rather than root out, the self-serving behavior of conflicted insurers. Such a consequence is not only unfair, but will continue to erode public confidence in the worth of private health, disability, life, and unemployment insurance and pension benefits. Of equal importance, it will continue to erode public confidence in the ability of the federal government to protect against abuses in the distribution of private benefits.

ARGUMENT

I. Applying An Administrative Law "Arbitrary And Capricious" Standard To Decisions By Conflicted ERISA Administrators Denies Claimants Their "Day In Court" And Prevents Claimants From Receiving The "Full and Fair" Treatment That Congress Intended Them To Receive When It Enacted ERISA

A. Equating ERISA Administrators With Unbiased Federal Agencies Denies Claimants An Unbiased Adjudication On The Merits Of Their Claims

Implicit in the Seventh Circuit's use of the highly deferential arbitrary and capricious standard to uphold the termination of Petitioner's benefits is the premise that decisions made by ERISA-governed benefit plans are administrative decisions that are not qualitatively different from the decisions rendered by impartial governmental agencies.[4] This equation is reflected in the use of the term "administrative decision" to refer to the resolution by the plan administrator of disputes with its participants and beneficiaries; the term "administrative record" to refer to the evidentiary record considered by the plan administrator; and the term "administrative

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[4] *Compare Motor Vehicle Mfrs. Ass'n. of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (remarking that under the "arbitrary and capricious" standard of the Administrative Procedure Act, "the agency must examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made" and that the court must "consider whether the decision was based on a consideration of the relevant actors and whether there has been a clear error of judgment") (internal quotation marks and citations omitted) *with Miller v. United Welfare Fund*, 72 F.3d 1066, 1070 (2d Cir. 1995) (describing an ERISA determination as "arbitrary and capricious [if it] is without reason, unsupported by substantial evidence or erroneous as a matter of law").

exhaustion" to refer to the exhaustion of the claim request process. *E.g.*, *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 982-83 (7th Cir. 1999) ("Deferential review of an administrative decision means review on the administrative record."); *Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410, 418 (6th Cir. 1998) ("The application of the administrative exhaustion requirement in an ERISA case is committed to the sound discretion of the district court . . . .").

This equation, however, is inappropriate and misleading, especially when the plan administrator has a conflict of interest. By any objective standard, there is a vast difference between the procedural safeguards provided by an administrative agency and a self-interested insurance company: a difference that will often decisively affect whether claimants actually receive the benefits for which they are eligible. Simply put, the adjudication of a claim by a neutral federal administrative agency—with no direct financial stake in the outcome and no fiduciary responsibility to profit-motivated shareholders—is vastly more likely to lead to a fair decision than a claim processed by a plan administrator with a conflict of interest. *See generally* Mark D. DeBofsky, *The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims*, 37 John Marshall L. Rev. 727 (2004). *Cf. Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987) (Posner, J.) ("Pension fund trusts are not administrative agencies and most of the decisions they make are not discretionary in the sense, familiar from administrative law, of decisions that make policy under a broad grant of delegated powers. Certainly in a case such as the present one, pension fund trustees are not policy-makers; they are interpreters of contractual entitlements.").

This Court has recently described the safeguards available in federal agency adjudications:

> There can be little doubt that the role of the modern federal hearing examiner or administrative law judge . . . is 'functionally comparable' to that of a judge. His powers are often, if not generally, comparable to those of a trial judge . . . . *More importantly, the process of agency adjudication is currently structured so as to assure that the hearing examiner exercises his independent judgment on the evidence before him, free from pressures by the parties or other officials within the agency.* . . . Federal administrative law requires that agency adjudication contain many of the same safeguards as are available in the judicial process. The proceedings are adversary in nature. They are conducted by a trier of fact insulated from political influence. . . . The parties are entitled to know the findings and conclusions on all of the issues of fact, law, or discretion presented on the record.

Federal Maritime Comm'n v. South Carolina State Ports Auth., 535 U.S. 743, 756-57 (2002) (internal citations and quotation marks omitted) (emphasis added).

By contrast, Petitioner's claim was denied by an insurance company that was anything but "functionally comparable" to a federal judge. Nor was the treatment he received substantially equivalent to that provided a federal agency claimant. "[I]mportantly," the company did not provide Petitioner with a "process of agency adjudication . . . structured so as to assure that the [decisionmaker] exercise[d] his independent judgment on the evidence before him, free from pressures by the parties or other officials within the agency." *Id.* at 756. All of the individuals with decision-making authority with respect to granting or denying Petitioner's claim were employees of the company and dependent on the company

for their livelihood. Pet. App. 11a-12a, 51a, 92a-94a. Had they decided to grant Petitioner's claim, it would have been paid, not from a separate trust, but out of the company's general assets. *See Brown v. Blue Cross & Blue Shield of Ala.*, 898 F.2d 1556, 1561 (noting that insurance companies are exempted from the usual requirement under ERISA that plan assets be held in a separate trust). In denying the claim, the company benefited its own financial interests and those of its shareholders to whom it owes a fiduciary obligation. *See id.* at 1564 n.1 ("[T]he individuals who occupy the position of ERISA fiduciaries are less well-insulated from outside pressures than are decisionmakers at government agencies."). Had the company granted the claim, it would have acted against these financial interests. *See id.* at 1561 ("Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business."); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000) ("[T]he typical insurance company is structured such that its profits are directly affected by the claims it pays out and those it denies.").

Nonetheless, when reviewing the insurer's decision, the district court and Seventh Circuit upheld the denial of benefits using essentially the same highly deferential "arbitrary and capricious" test that they would have used in reviewing administrative agency decisions—that is, decisions rendered by unbiased, expert administrative agencies that provide claimants with a raft of attendant safeguards. As this Court noted in *Federal Maritime Commission*, those safeguards are substantially the same as those provided by trial judges. Because administrative agencies provide those protections, trial courts are not necessarily acting unfairly when they review agency decisions with the same deference that appellate courts often use to review trial court decisions; in both situations the deferential review takes place *after* a proceeding in

which the plaintiff or appellant has been provided with either a trial or trial-like safeguards, including having the decision rendered by an adjudicator—be it a judge, a jury, or an administrative law judge—who has no conflict of interest. In both situations the person seeking relief has a meaningful "day in court."

The situation for Petitioner was the exact opposite. At the time he filed suit, he had not already enjoyed the fair treatment that administrative agencies provide to claimants, including the basic procedural safeguard of having his case decided by an adjudicator without a conflict of interest. In according a high level of deference to the insurer's decision in this case, the district court and the Seventh Circuit failed to afford Petitioner the fundamental fairness that Congress wanted beneficiaries to enjoy when it enacted ERISA. Petitioner never had his day in court.

B. The Statutory Provisions Of ERISA Offer No Basis For According Conflicted ERISA Administrators Deference Under An "Arbitrary And Capricious" Standard Of Review

The treatment by the courts of suits brought under ERISA as if they were requests for judicial review of federal agency decisions runs squarely counter to the manner in which Congress intended ERISA to be enforced. The statutory mechanisms for enforcement applicable to a denial of benefits or breach of fiduciary duty under 29 U.S.C. § 1132(a) do not provide participants or beneficiaries with relief in an administrative agency. ERISA actions under Section 1132(a) allow relief to be sought solely from courts. 29 U.S.C. § 1132(a) ("A *civil action* may be brought . . . .") (emphasis added). Moreover, Section 1132(a) uses none of

the language found in statutes authorizing suits in the nature of appeals of agency decisions.[5]

Had they wished to indicate such an intention, the drafters of ERISA could have easily done so by inserting language of this kind. But this was not their intent, as is revealed by the statute's "carefully crafted and detailed enforcement scheme." *Mertens v. Hewitt Associates*, 508 U.S. 248, 254 (1993) (citation omitted). Rather than employing the conventional language of administrative law,[6] "ERISA abounds with the language and terminology of trust law." *Firestone*, 489 U.S. at 110. When district courts preside over ERISA suits, they do not sit as courts of appeal, but as courts of equity protecting the interests of trust beneficiaries. George G. Bogert & George T. Bogert, *Handbook of the Law of Trusts*, ch. 18 (5th ed.

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[5] For example, unlike the judicial review provisions of the Administrative Procedure Act ("APA"), 5 U.S.C. § 706, Section 1132(a) does not refer to the court in which an ERISA claimant seeks redress as a "reviewing court." *Id.* Nor, unlike the APA, does it have an explicit limitation of *de novo* review only to facts that "are subject to de novo review," 5 U.S.C. § 706(2)(F), a limitation that permits *de novo* judicial review of adjudications only if the "agency's factfinding procedures are inadequate." *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 415 (1971). Nor, unlike the APA, does section 1132(a) contain language indicating the legislature's intention to create only limited judicial review in the form of an "appeal" of agency action. 5 U.S.C. § 706(2)(A).

[6] In the debates preceding the enactment of ERISA, Congress considered an amendment providing for benefit disputes to be brought before "hearing examiners . . . appointed pursuant to the Administrative Procedure Act." 2 Subcommittee on Labor of the Senate Committee on Public Labor and Public Welfare, 94th Cong. 2d Sess., Legislative History of the Employee Retirement Security Act of 1974, at 1335-1836 (Comm. Print 1976). The hearing examiners would have presided over trial-like evidentiary hearings, which would have been governed on appeal by the Administrative Procedure Act. *Id.* Because Congress did not adopt this approach, it is permissible for plan decisions to be rendered by conflicted adjudicators. *Id.* at 1838. What is not permissible is for the federal courts to treat challenges to such decisions as if they had been rendered with the safeguards provided by federal administrative agencies.

1973) (noting that courts of equity traditionally exercise broad supervision over trustees). Indeed, it is one of the distinctive characteristics of ERISA that all of its remedies are in their essence equitable. *Sullivan v. LTV Aerospace and Defense Co*, 82 F.23 1251, 1258 (2d Cir. 1996); *cf. Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002). As a corollary, district courts are presumptively required to review plan decisions with the high level of care that courts of equity exercise when they review the decisions of trustees, rather than with the deference ordinarily provided the actions of government agencies. *Firestone*, 489 U.S. at 111. In accordance with principles of trust law, this duty is heightened when a court reviews the decision of an insurer subject to financial interests conflicting with those of a participant or beneficiary; in such cases, a court may provide the decisionmaker with the least degree of deference or no deference at all. Restatement (Second) of Trusts § 170(1) cmts. a-h (1959); *id.* at § 187.

II. Failure To Resolve The Problem Raised By Petitioner Risks Further Erosion Of Public Confidence in ERISA-Governed Benefit Plans To Provide Promised Benefits

The principal problem ERISA was intended to remedy was the unexpected and unfair loss of benefits. *Rettig v. PBGC*, 744 F.2d 133, 135-36 & n.2 (D.C. Cir. 1984) ("Congress sought to remedy the predicament of thousands of employees whose expectations of adequate retirement income were destroyed by stingy pension plan provisions, bad management or inadequate funding."); *Duchow v. New York State Teamsters Conf. Pension & Ret. Fund*, 691 F.2d 74, 76 (2d Cir. 1982) ("ERISA was designed to reduce, by various means, the number of pension benefits lost."). The rule challenged by Petitioner patently subverts that goal. Employee benefits are not

gratuities. When ERISA-regulated plans promise that benefits will be paid under specified circumstances, such as the reaching of retirement age or becoming disabled, an employee or beneficiary to whom the promise has been made has the right to expect that the benefit will be paid. *Firestone*, 489 U.S. at 113.

Inherent in fulfilling that expectation is the requirement that any dispute about whether those circumstances actually exist will be adjudicated fully and fairly. 29 U.S.C. § 1133. Employees and their beneficiaries cannot be expected to view an adverse benefit determination rendered by a conflicted adjudicator as fair. The unfairness of conflicted adjudication is obvious to them. It was implicit in the lesson taught to them as children when their teachers explained the necessity for an independent judiciary; it is consistent with their common sense and their common experience. And it is, of course, implicit in, and consistent with, the codes of conduct to which judges themselves are subject, codes that not only prohibit decisions tainted by conflicts of interests but decisions that even have the appearance of being so tainted. *See* ABA Model Code of Judicial Conduct, Canon 2, Comment ("A judge must avoid all impropriety and appearance of impropriety."); *id.*, Canon 5(C)(1) ("A judge should refrain from financial and business dealings that tend to reflect adversely on his impartiality . . . .").

The confidence of workers and their dependents is not mitigated by knowledge that, if they are somehow able to "prove" by external evidence that the conflict of interest affected the decision, the courts will provide less deferential review. Their knowledge of this theoretical possibility is eclipsed by their knowledge that, as a practical matter, uncovering the specific evidence needed to meet this burden will almost always be impossible. This is amply demonstrated by a review of cases decided by the Second Circuit and by the district courts thereunder. From the time the rule in *Pagan* was

adopted ten years ago to October 12, 2005, there have been 33 such cases whose ultimate outcome has been published.[7] In only one of these cases did the court actually find that less deferential review was merited because the plaintiff had made a showing that the conflict had affected the adverse decision; the one successful plaintiff was an attorney at the law firm Paul, Weiss,

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[7] *Smith v. First UNUM Life Ins. Co.*, 2005 WL 2475724 (2d Cir. 2005); *Waksman v. IBM Separation Allowance Plan*, 138 Fed. Appx. 370 (2d Cir. 2005); *Kirk v. Readers Digest Assoc.*, 57 Fed. Appx. 20 (2d Cir. 2003); *Caidor v. Chase Manhattan Bank*, 29 Fed. Appx. 704 (2d Cir. 2002); *Parry v. SBC Communications, Inc.*, 375 F. Supp.2d 31 (D. Conn. 2005); *Badawy v. First Reliance Standard Life Ins. Co.*, 2005 WL 2396908 (S.D.N.Y. 2005); *Nerys v. Building Services*, 2004 WL 2210256 (S.D.N.Y. 2004); *Owen v. Wade Lupe Construction Co.*, 325 F. Supp.2d 146 (N.D.N.Y. 2004); *Chan v. Hartford Life Ins. Co.*, 2004 WL 2002988 (S.D.N.Y. 2004); *Snyder v. First Unum Life Ins. Co.*, 2004 WL 1784334 (W.D.N.Y. 2004); *Cook v. New York Times Co. Long-Term Disability Plan*, 2004 WL 203111 (S.D.N.Y. 2004); *Wagner v. First Unum Life Ins. Co.*, 2003 WL 21960997 (S.D.N.Y. 2003); *Shutts v. First Unum Life Ins. Co.*, 310 F. Supp.2d 489 (N.D.N.Y. 2004); *Doe v. Cigna*, 304 F. Supp.2d 477 (W.D.N.Y. 2003); *Bergquist v. Aetna U.S. Healthcare*, 289 F. Supp.2d 400 (S.D.N.Y. 2003); *Armstrong v. Liberty Mutual Life Assur. Co.*, 273 F. Supp.2d 395 (S.D.N.Y. 2003); *Henar v. First Unum Life Ins. Co.*, 2002 WL 31098495 (S.D.N.Y. 2002); *Maniatty v. Unumprovident Corp.*, 218 F. Supp.2d 500 (S.D.N.Y. 2002); *Rosenthal v. First Unum Life Ins. Co.*, 2002 WL 975627 (S.D.N.Y. 2002); *Thompson v. General Elec. Co.*, 2002 WL 482862 (S.D.N.Y. 2002); *Zervos v. Verizon New York, Inc.*, 2001 WL 1262941 (S.D.N.Y. 2001), *rev'd on other grounds*, 277 F.3d 635 (2d Cir. 2002); *Schwartz v. Oxford Health Plans*, 175 F. Supp.2d 581, 590-91 (S.D.N.Y. 2001); *Corvi v. Eastman Kodak Co. Long Term Disability Plan*, 2001 WL 484008 (S.D.N.Y. 2001); *Flynn v. Hach*, 138 F. Supp.2d 334 (E.D.N.Y. 2001); *Roberton v. Citizens Utilities Co.*, 122 F. Supp.2d 279 (D. Conn. 2000); *Risenhoover v. Bayer Corp.*, 83 F. Supp.2d 408 (S.D.N.Y. 2000); *Administrative Committee of the Time Warner, Inc. v. Biscardi*, 2001 WL 286749 (S.D.N.Y. 2000); *Montesano v. Xerox*, 117 F. Supp.2d 147 (D. Conn. 2000); *Boesel v. The Chase Manhattan Bank*, 62 F. Supp.2d 1015 (W.D.N.Y. 1999); *Weissman v. First Unum Life Ins. Co.*, 44 F. Supp.2d 512 (S.D.N.Y. 1999); *DeVere v. Northrop Grumman Corp.*, 1999 WL 182670 (E.D.N.Y. 1999); *Elsroth v. Consolidated Edison*, 10 F. Supp.2d 427 (S.D.N.Y. 1998); *Semmler v. Metropolitan Life Ins. Co.*, 172 F.R.D. 86 (S.D.N.Y. 1997).

Rifkind, Wharton & Garrison. *Schwartz v. Oxford Health Plans*, 175 F. Supp.2d 581, 590-91 (S.D.N.Y. 2001) (finding a conflict of interest that affected the denial of benefits where insurer had recently announced large operating losses, repeatedly advised claimant to use an in-network provider, failed to explain its decision to the claimant, and offered weak arguments in support of its position). These numbers, of course, do not indicate the full scope of the problem, since the generally insurmountable burden of proof has undoubtedly discouraged many plaintiffs from even raising the issue. This is especially so given that the evidence necessary is by definition in the sole possession of the insurer, and uncovering such a conflict of interest requires significant resources well beyond the means of the disabled or elderly workers and their dependents for whose benefit ERISA was enacted. *See generally* Peter A. Meyers, Comment, *Discretionary Language, Conflicts of Interest, and Standard of Review for ERISA Disability Plans*, 28 Seattle L. Rev. 925, 925-927 & nn.5 & 16 (2005) (and sources cited therein).[8]

The loss by employees and their dependents of faith in the system of ERISA-regulated benefit plans to provide

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[8] In addition to recounting the difficulties in ERISA plaintiffs gathering sufficient evidence to show a conflict, Peter A. Meyers describes the widespread national media coverage of the abusive practices of the largest disability insurer in the nation—attention that has surely shaken faith in the private disability benefits system. *Id.* at 925 n.5. *See generally* Peter G. Gosselin, *State Fines Insurer, Orders Reforms in Disability Cases*, Los Angeles Times, Oct. 3, 2005, at A1; Peter G. Gosselin, *The New Deal; The Safety Net She Believed In Was Pulled Away When She Fell*, Los Angeles Times, August 21, 2005, at A1; *Did Insurer Cheat Disabled Clients?*, 60 Minutes, CBS News, Nov. 17, 2002, *available at http://www.cbsnews.com/stories/2002/11/15/60minutes/main529601.shtml*; John Larson & Lea Thompson, *Benefit of the Doubt; Several People Accuse Insurance Company UnumProvidence [sic] of Searching for Reasons to Deny Claims*, Dateline NBC, Oct. 12, 2002, *available at* LEXIS, NEWS-ALL database.

promised benefits has brought with it another problem: a loss of faith in the willingness and capacity of the government to ensure their fair treatment. By all but proclaiming indifference to whether or not a plan adjudication by a conflicted administrator was actually correct, *see, e.g.*, *Mers v. Marriot Int'l Group Accid. Death & Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998), the Seventh Circuit exacerbates the continued loss of faith by employees and their dependents in ERISA's ability to serve its aim of eliminating abuses in the distribution of benefits. Announcing the irrelevance of fairness in this case—despite the presence of a irreconcilable conflict of interest that prevented a "fair" decision by the ERISA insurer—the court below stated that it was unconcerned with whether Petitioner was actually eligible for the benefits he was denied because, in the court's view, "[u]nder the arbitrary and capricious standard we do not ask if the administrator reached the correct decision or even whether it relied upon the proper authority." *Kobs*, 400 F.3d at 1039. Needless to say, such proclamations of indifference to fairness can only work to undermine public belief that the enforcement of ERISA does justice.[9]

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[9] The fair administration of pension plans is not merely a concern of their participants and beneficiaries. The entire tax-paying public has a direct interest in ensuring that the federal courts make full use of their equitable powers when reviewing suits by claimants whose benefits have been denied without the benefit of an independent decisionmaker and without the judicial-type safeguards that are at the core of the Anglo-American system of justice. Of particular concern to the public, these biased adjudications are made by plans that reap considerable benefits as a result of tax exclusions under Title I of the Internal Revenue Code. The price paid by the Treasury Department is significant. The loss of otherwise taxable income in 2003 due to exclusions relating to employer and individual contributions to retirement and health plans, respectively, is estimated at $279.1 billion and $569.9 billion. Majority Staff of the House Comm. on Ways and Means, 108th Cong. 2d sess., 2004 Green Book, Background Material on Data on the Programs Within the Jurisdiction of the Committee on Ways and Means Table 13-2 (Comm. Print Mar. 2004),

This loss of public faith is hardly restored when judges themselves lament that "ERISA has gone conspicuously awry from its original intent" and "has evolved into a shield of immunity which thwarts the legitimate claims of the very people it was designed to protect." *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 56, 65 (D. Mass. 1997) (Young, J.). Nor is confidence bolstered when a panel of judges in the Second Circuit, despite acknowledging the binding nature of prior precedent, went so far as to announce that *Pagan* "fail[ed] to give weight to" this Court's instruction in *Firestone* that a conflict of interest should be "weighed as a factor" in judicial review. *DeFelice v. American Int'l Life Assurance Co.*, 112 F. 3d 61, 66 (2d Cir. 1997) (quoting *Firestone*, 489 U.S. at 115).

The importance that people not only be treated fairly but also have confidence in the government's capacity to act, if necessary, to make sure they are treated fairly, has been explained by Justice Frankfurter:

> The heart of the matter is that democracy implies respect for the elementary rights of men, however suspect or unworthy; a democrat government must therefore practice fairness; and fairness can rarely be obtained by secret, one-sided determination of facts decisive of rights. . . . Man being what he is cannot safely be entrusted with complete immunity from outward responsibility in depriving others of their rights. . . . The validity and moral authority of a conclusion largely

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available at http://www.gpoaccess.gov/wmprints/green/2004.html. To say the least, it was not Congress's intention that conflicted plans be permitted to reap the benefits of tax qualification—by being paid in more valuable pre-tax dollars—while the employees and their beneficiaries for whose protection ERISA was enacted are denied redress to independent courts that will impartially exercise their full equitable powers to ensure that participants and beneficiaries actually receive the benefits for which they are eligible.

> depend on the mode by which it was reached . . . . "In a government like ours, entirely popular, care should be taken in every part of the system, not only to do right, but to satisfy the community that right is done."

Joint Anti-Fascist Refugee Committee v. McGrath, 341 U.S. 123, 170-172 & n.19 (1951) (Frankfurter, J., concurring) (quoting 5 *The Writings and Speeches of Daniel Webster* 163) (other citations and footnotes omitted).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

GARY STONE
Counsel of Record
JONATHAN A. WEISS
LEGAL SERVICES FOR THE ELDERLY
130 West 42nd Street
17th Floor
New York, New York 10036-7803
(646) 442-3316

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No. 05-394

IN THE

Supreme Court of the United States

ELVIS KOBS,

Petitioner,

v.

UNITED WISCONSIN INSURANCE COMPANY,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

REPLY BRIEF FOR THE PETITIONER

LAURA W. BRILL
Counsel of Record
TED M. SICHELMAN
IRELL & MANELLA, LLP
1800 Avenue of the Stars
Los Angeles, California
90067
(310) 277-1010

JASON W. WHITLEY
NOVITZKE, GUST, SEMPF
& WHITLEY
314 Keller Avenue North,
Suite 399
Amery, Wisconsin 54001
(715) 268-6130

Counsel for Petitioner Elvis Kobs

November 14, 2005

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I. UWIC Does Not Dispute The Key Factors That Make This Case Worthy Of Certiorari

Respondent UWIC's Brief in Opposition to the Petition for Certiorari ("Opp.") is notable for its failure to contest the numerous factors that make this case an ideal vehicle for review. For example, UWIC makes no attempt to contest that the questions presented concern deeply entrenched splits among the circuits on matters of significant national importance that need to be resolved by this Court. Nor does UWIC contest that it is a "dual-role" insurer.[1] Finally, UWIC does not dispute that the judgment of the Seventh Circuit is final, that the medical evidence is in conflict, or that the Seventh Circuit expressly stated that its "deferential" standard of review was material to its decision. Opp. 5-9, 12-13.

Rather than disputing these key factors, UWIC goes to great lengths to cloud the issues, concocting arguments that are largely irrelevant to whether the petition should be granted. In so doing, UWIC distorts the proceedings below, ignores the procedural posture of this case, posits impossible hypotheticals, and mischaracterizes the possible outcomes of a decision by this Court. As explained in more detail below, none of UWIC's arguments establishes any true "vehicle problem" with this case.[2]

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[1] *See* Opp. 3 (noting that disability plan was "administered and insured by Respondent"). *See also* Pet. App. 34a, 40a (plan documents); *id.* at 15a (district court noting that "defendant acted as both plan administrator and insurer"); *id.* at 5a (circuit court analyzing effect of UWIC's "dual role").

[2] This case has none of the substantive or procedural flaws of the other cases relating to conflicted ERISA insurers that this Court has recently declined to address. *See, e.g.*, Petition for Certiorari, *Merck & Co., Inc. v. Epps-Malloy*, *cert. denied*, 125 S. Ct. 2252 (May 16, 2005) (No. 04-995), 2005 WL 175921 (focusing on relationship

II. This Court Should Not Defer Resolution Of The Important Questions Presented In This Case Pending The Advent Of UWIC's Hypothetical "Ideal" Vehicle

This case raises two significant questions: First, whether the dual role of an ERISA fiduciary insurer constitutes an inherent conflict of interest that must be considered in the judicial review of denials of claims; and, second, if the answer to the first question is "yes," what is the appropriate means to consider the conflict of interest. UWIC argues that this Court should refrain from resolving either question unless it is faced with a case in which it is certain to be able to answer both. Opp. 13. UWIC is misguided.

Importantly, UWIC does not deny that if this Court were to answer "yes" to the first question presented, then this Court could reach the second question. *See* Opp. 13, 19-23. Moreover, the first question presented is itself a matter of substantial national importance on which circuit courts are hopelessly divided. Pet. 10-13. Answering this question alone will provide important guidance to federal courts that consider thousands of ERISA cases per year involving dual-role insurers. *Id.* at 22-25. Thus, this issue should be resolved whether or not the Court is able to reach the second question in the same case. The policies of ERISA demand a uniform rule: either an inherent conflict is sufficient to be considered in

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between independent medical examinations and general conflicts of interest, as opposed to inherent conflicts of interest); *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997 (10th Cir.) (non-final decision containing complex, tangential issues), *cert. denied*, 125 S. Ct. 1972 (May 2, 2005); Petition for Certiorari, *Peach v. Ultramar Diamond Shamrock*, *cert. denied*, 125 S. Ct. 1641 (Mar. 21, 2005) (No. 04-919), 2004 WL 3057828 (presenting (1) vague question whether different standards of review in conflict cases are inconsistent with goals of ERISA, and (2) fact-specific question of whether ERISA administrator's decision was actually "arbitrary and capricious").

judicial review of benefits denials or it is not. *Id.* at 10-13. *See generally Aetna Health Inc. v. Davila*, 542 U.S. 200, 124 S. Ct. 2488, 2495 (2004) (noting that the "purpose of ERISA is to provide a *uniform* regulatory regime over employee benefit plans") (emphasis added). UWIC does not argue that there are any barriers to this Court's consideration of the first question presented.

In addition, there will never be a case in which the first question is squarely before the Court and in which the Court can be assured of reaching the second question. Specifically, if this Court were to decide the first question and find that an insurer's dual role does not constitute a conflict of interest to be considered in judicial review, and in any such case the claimant had not obtained evidence of a conflict beyond the fact of the dual role, this Court would never reach the second question. Conversely, any case with substantial additional evidence of a conflict beyond the insurer's dual role would not be a proper vehicle to resolve the first question. In such a case, although the Court could reach the second question, any ruling on the first question—i.e., whether the dual role, *alone*, should be considered in the judicial review of claim denials—would be mere dicta. Thus, UWIC's hypothetical "ideal" case is merely "imaginary."

In a related argument, UWIC contends that this case is not an ideal vehicle because Petitioner did not appeal from the district court's order denying him the opportunity to take discovery. This contention is irrelevant to the questions presented. It is important to understand the limited scope of UWIC's waiver argument. UWIC contends that "[i]f this Court rules that an ERISA claimant is required *to prove something more than an 'inherent' conflict* in order to modify the abuse of discretion standard, such a decision will make no difference in this case because Petitioner has not preserved his opportunity to meet this standard." Opp. 21 (emphasis added). In other words, UWIC is arguing

that if this Court answers the first question presented in the negative, then this Court will not reach the second question presented, and there will be no remand. Assuming UWIC were correct, that would hardly be a reason not to grant the petition in this case, because the first question alone is worthy of certiorari.

In addition, UWIC does not dispute that if this Court answers the first question presented in the affirmative, then further discovery on remand may well be appropriate in order to apply whatever legal standard this Court may announce. *See, e.g., Johnson v. California*, __ U.S. __, 125 S. Ct. 1141, 1152 (2005) (adopting more stringent standard of review than lower court and remanding for determination under new standard); *id.* at 1172 (Thomas, J., joined by Scalia, J., dissenting) (noting that because losing party was subject to a more stringent standard of review, it should, upon remand, "be allowed to present evidence of narrow tailoring, evidence it was never obligated to present in either appearance before the District Court"). *See also Rengers v. WCLR Radio Station, a Div. of Bonneville Intern. Corp.*, 825 F.2d 160, 165 (7th Cir. 1987) ("[D]efendant's failure to object waived its right to challenge the instruction as incorrect in view of other Circuits' decisions, but it did not act as a waiver to challenge the instruction on the basis of an intervening Supreme Court decision and consequent change in the law.").

III. Whether Petitioner Presented Evidence Of A Conflict Beyond Respondent's Dual Role Is Irrelevant To Whether Respondent Has An Inherent Conflict Of Interest

UWIC additionally contends that the district court and Seventh Circuit "carefully considered the potential for bias" by examining the specific facts in the record in this case. Opp. 1, 14-19. This argument again overlooks

the questions presented and mischaracterizes the Seventh Circuit's opinion.

In particular, the first question presented in this case is whether a dual-role insurer "*inherently* acts under a conflict of interest to be considered in the judicial review of a denial of benefits." Pet. i (emphasis added). This question asks whether, *based solely on an insurance company's dual-role status*, there is a conflict of interest to be considered in judicial review. Evidence regarding UWIC's procedures does not address this question or alter its importance. Moreover, there was no conclusion by the Seventh Circuit that UWIC's procedures demonstrated that its decision was uninfluenced by its conflict of interest. Rather, the Seventh Circuit presumed that there was no conflict and placed the burden on Mr. Kobs to rebut that presumption. Pet. App. 5a-6a.

In addition, depending upon the appropriate test used to consider the conflict of interest, evidence of the procedures of an inherently conflicted insurer may, as a matter of law, be insufficient to rebut a finding that there was a conflict. *E.g.*, *Fought v. Unum Life Ins. Co. of America*, 379 F.3d 997, 1004-06 (10th Cir. 2004) (adopting irrebuttable presumption of a conflict of interest based on inherent conflict of an insurer). Because this Court has not yet determined what test should apply, it is premature to assess how UWIC's procedures may be weighed in this case.

In asserting that it acted without bias, UWIC argues that the Seventh Circuit employs a fact-specific test and "refuses to engage in general assumptions about insurer bias." Opp. 16. UWIC misreads Seventh Circuit case law. Far from avoiding economic assumptions, the Seventh Circuit's legal standard presumes that dual-role insurers, which have structural financial incentives to act

against the interests of beneficiaries, will not do so.[3] The Seventh Circuit makes further policy assumptions in placing the burden on ERISA beneficiaries, who are by definition likely to be sick or otherwise vulnerable, to develop evidence on a case-by-case basis of information about bias that is typically in the sole possession of the insurer. The majority of circuits addressing conflicts of dual-role insurers do not agree that the economic realities or the policies of ERISA justify allocating burdens in this way. Pet. 10-11.

Petitioner's evidence regarding the practices of other insurance companies, Pet. 26-27, underscores the error of the Seventh Circuit's standard and supports the conclusion of the majority of circuits that the financial interests of insurance companies create significant recurring incentives for insurers to engage in self-serving behavior. Indeed, UWIC acknowledges that "insurers are in business to make a profit and it is not impossible that there may be a temptation in some cases to deny borderline claims." Opp. 14-15.

Accordingly, the professed "neutrality" of UWIC and its interpretation of the Seventh Circuit's rule do not provide a basis for denying the petition for certiorari.

IV. The Standard Of Review Is Outcome Determinative Of The Decision Below

UWIC devotes ten pages to a fact-intensive "Counterstatement of the Case" and spends another six pages arguing that Mr. Kobs would lose below under any

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[3] *See, e.g., Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020-21 (7th Cir. 1998) ("The impact of granting or denying benefits in this case is minuscule compared to AIG's bottom line."). *Cf. Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000) ("insurance carriers have an active incentive to deny close claims in order to keep costs down . . . , an economic consideration overlooked by the Seventh Circuit").

test. Opp. 3-13, 23-28. Despite the length of its argument, UWIC does not dispute that genuine issues of material fact exist in this case. On the orthopedic issues, for example, two examining physicians support Mr. Kobs's position and one supports UWIC's position; on the cognitive issues, two examining physicians support Mr. Kobs's position and two support UWIC's position.[4] Thus, UWIC's position that granting it summary judgment would be appropriate under any test that this Court might adopt is simply wrong. In fact, the Seventh Circuit specifically noted the importance of the standard of review in reaching its result. Pet. App. 9a.

As an initial matter, UWIC misreads this Court's holding in *Firestone* to conclude that *de novo* review is never appropriate to review decisions of conflicted administrators. Although this Court held in *Firestone* that an "abuse of discretion" standard must be applied when a plan grants discretionary authority to an ERISA administrator or fiduciary, this does not preclude that

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[4] UWIC noticeably omits Dr. Melby's diagnosis of "memory loss," Pet. App. 55a-56a, from its discussion regarding Petitioner's "psychiatric/psychological complaints." Opp. 6-9. Moreover, the assertion that "at least three experts determined that Petitioner was 'sandbagging' during testing, including a neuropsychologist who tested Petitioner on a referral from Petitioner's own doctor" is distortion and hyperbole. Opp. 2. First, Dr. Mary Sullivan, the psychologist who saw Mr. Kobs on referral, diagnosed Mr. Kobs with a "psychological disturbance . . . which would render it difficult for him to be a fully engaged worker." Pet. App. 79a. Dr. Sullivan also noted that she believed Mr. Kobs's "performance" on her evaluations "raise[d] questions about the effort he exerted," but she remarked that "these efforts . . . were *not done deliberately*, e.g., with the intent to deceive." *Id.* at 77a-78a (emphasis added). Dr. Philip Sarff, a psychologist hired directly by UWIC opined that Mr. Kobs "consciously or unconsciously exaggerated symptoms." *Id.* at 85a. These statements are hardly findings of "sandbagging." Finally, Nurse Francine Blaha's incomplete recounting of Dr. Sullivan's and Dr. Sarff's reports can scarcely be termed a diagnosis. *Id.* at 91a. UWIC's "sandbagging" mantra also fails to recognize the gravity of Mr. Kobs's losses. Forfeiture of one's home and car are far from the acts of a "sandbagger." Pet. 5.

standard from effectively becoming a *de novo* standard in certain instances. In particular, four circuits hold that when an ERISA administrator acts under a conflict of interest, there should be no deference given to the administrator. The result is that these circuits examine the denial of benefits under an effective *de novo* standard.[5] This is consistent with black-letter trust law, which allows a court to "void" a decision of a trustee administering a trust under a conflict of interest. *See* Restatement (Second) of Trusts § 170(1) cmts. a-h (1959); *id.* at § 187. Under any of these circuits' approaches, UWIC would not have been entitled to summary judgment in the face of genuine issues of material fact in dispute. *E.g.*, *Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 978 (9th Cir. 1999) (applying *de novo* standard that deems conflicted decisions to be "presumptively void," and holding that "[b]ecause there are genuine issues of material fact in dispute as to whether Tremain was disabled and as to whether she was a 'salesman,' her entitlement to benefits and the amount of those benefits may not be decided by summary judgment").[6]

Finally, UWIC contends that even if summary judgment in its favor was not appropriate, Petitioner would lose at trial, because summary judgment in the ERISA context is equivalent to a trial. This assertion again misstates the law. As noted above, if this Court

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[5] *Fought*, 379 F.3d at 1004-06; *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996); *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995); *Brown v. Blue Cross & Blue Shield of Ala.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990).

[6] Even under a sliding scale test, following further discovery below, it is likely that summary judgment would not be appropriate. *E.g.*, *Pinto*, 214 F.3d at 393-95 (finding that summary judgment was inappropriate under a sliding scale approach where physicians' opinions conflicted and "a factfinder could conclude that [the insurer's] decision to credit its doctors . . . was the result of self-dealing instead of the result of a trustee carefully exercising its fiduciary duties").

reverses and remands, Mr. Kobs would be able to conduct, in the very least, further discovery regarding the extent and nature of UWIC's conflict—which Respondent does not dispute.[7] This evidence, for example, may lead the district court to lessen its reliance on the medical opinions of physicians hired by UWIC.

Furthermore, it is premature to speculate what evidence may be admissible at trial on remand. When an ERISA administrator is conflicted, the rationale for the judge relying solely on the written administrative record and not second-guessing the administrator is diminished or absent. In *Locher v. UNUM Life Ins. Co of Am.*, 389 F.3d 288 (2d Cir. 2004), for example, the Second Circuit examined one of its earlier decisions admitting evidence outside of the "administrative record." *Id.* at 290-91 (citing *DeFelice v. American International Life Assurance Co. of New York*, 112 F.3d 61 (2d Cir. 1997)). Although the admission of evidence in *DeFelice* was not based solely on an inherent conflict, the *Locher* court stated "that it may be possible, in unforeseen circumstances, for good cause [sufficient to justify the admission of evidence outside the administrative record] to rest entirely on the existence of a conflicted administrator." *Id.* at 296. *See also id.* at 293 ("When an administrator is conflicted . . . plaintiffs are utterly helpless against the whim of its interpretation of the facts, and the fairness of the ERISA appeals process cannot be established using only the record before the administrator.") (citations, internal quotation marks, and brackets omitted). In this instance, Petitioner would seek to introduce evidence such as the Social Security Administration decision in his favor and

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[7] Indeed, in the very case cited by UWIC for the proposition that "review is based only on the administrative record," Opp. 27-28, the First Circuit noted that a typical exception exists where "a claim of personal bias by a plan administrator" is asserted. *Orndorff v. Paul Revere Life Ins. Co.*, 404 F.3d 510, 520 (1st Cir.), *cert. denied*, 2005 WL 2493925, 74 U.S.L.W. 3108 (Oct. 11, 2005).

the fact of the foreclosure on his home and repossession of his car to rebut statements questioning his credibility. Pet. 5, 7 n.4. Thus, what the full scope of evidence at trial would be in this case cannot be predicted without knowing the substance of a decision by this Court.

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For the foregoing reasons and those stated in the petition and in the amicus brief of Legal Services for the Elderly, the petition for a writ of certiorari should be granted.

Respectfully submitted,

LAURA W. BRILL
Counsel of Record
TED M. SICHELMAN
IRELL & MANELLA, LLP
1800 Avenue of the Stars
Los Angeles, California
90067
(310) 277-1010

JASON W. WHITLEY
NOVITZKE, GUST, SEMPF & WHITLEY
314 Keller Avenue North,
Suite 399
Amery, Wisconsin 54001
(715) 268-6130

Counsel for Petitioner Elvis Kobs

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